101-14

COSMETIC SURGERY PROCEDURES: STANDARDS, QUALITY, AND CERTIFICATION OF NONHOSPITAL OPERATING ROOMS—PART III

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES, AND ENERGY

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

WASHINGTON, DC, JUNE 28, 1989

Printed for the use of the Committee on Small Business

Serial No. 101-14

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COSMETIC SURGERY PROCEDURES: STANDARDS, QUALITY, AND CERTIFICATION OF NONHOSPITAL OPERATING ROOMS—PART III

WEDNESDAY, JUNE 28, 1989

House of Representatives,
Subcommittee on Regulation,
Business Opportunities, and Energy,
Committee on Small Business,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:42 a.m., in room 2359-A, Rayburn House Office Building, Washington, DC, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman Wyden. The Subcommittee on Regulation, Business Opportunities, and Energy will come to order.

Today, the subcommittee continues its investigation into the booming beauty business. Thousands of Americans spend billions of dollars for cosmetic surgery each year, and too many are being maimed and disfigured from facelifts, liposuction, breast enlargement, and tummy tuck. Our 8-month investigation has uncovered a deadly triangle: Untrained doctors practicing new procedures on unsuspecting patients; unbridled, deceptive, and misleading advertising that legitimizes poor quality medical care; and unlicensed, uninspected outpatient cosmetic surgery facilities that are out of reach of the accrediting authorities. Each corner of this triangle ought to be considered separately. The Chair of this subcommittee is convinced that false and deceptive advertising in cosmetic surgery has become a growth industry because the Federal Trade Commission has given the green light to charlatans and hucksters who are out to make a fast buck at the consumer's expense.

Snake oil salesmen are not new to this Nation. The cosmetic surgery come-on is fed with 20th century marketing techniques. There is more glitz and more hype, but the message is the same: Be more beautiful, be happy and successful. There is gain and no pain. There is a quick, easy, and painless way to change your life—all through the cosmetic surgery miracle. In our youth-oriented society, the self-described miracle workers are looking for the gullible. They are aided by the Federal Trade Commission that in the name of promoting competition has hamstrung State regulators trying to protect their consumers, and in their misplaced laissez faire zeal, the FTC has twisted restraint of trade laws to strip medical societies of the ability to police their own.

The current Chairman of the Federal Trade Commission, Dan Oliver, continues to tell us that it's just not so. But Dan Oliver's position on cosmetic surgery advertising can't even win majority support of his own Federal Trade Commission. So, cosmetic surgery consumers are largely on their own. It is back to a buyer beware market, and it smacks more of used car sales than medicine.

Fortunately, more and more health care providers believe that the FTC's bizarre notions of encouraging competition in health care are doing more harm than good. Just last week, the American Medical Association referred a resolution to its board of trustees, stating, and I quote: "The American public has been endangered by deceptive, untruthful medical advertising promising risk-free, pain-free outpatient treatment and surgery without loss of time from work and results far beyond reasonable expectations."

The American Medical Association's new resolution calls for the FTC to establish standards governing truthful, nondeceptive, and nonmisleading advertising. The AMA believes that the FTC has effectively barred medical societies and State licensing boards, and I quote, "from establishing meaningful standards for medical advertising that is truthful, informative, and not deceptive."

Hype and deceptive advertising are not the only injustices perpetrated on too many cosmetic surgery patients. There are two other trends that have helped jerk the safety net out from under the cosmetic surgery patient. First, nearly 95 percent of all cosmetic surgery is done in doctor's offices beyond the protective eye of hospital review committees. Too often, there is no peer review of a doctor's work, his staff, or his equipment. It is simply not required, and the doctor's grandly titled surgery center or institute in his office doesn't have to be licensed, and it doesn't have to be inspected.

Outpatient facilities can offer patients cheaper care, more convenience, and more privacy, but they can also be a refuge for the unqualified, the unscrupulous, and the untrained, and a magnet for patient abuse. Unchecked and unaccountable facilities are an invitation to bad quality medical care. This subcommittee knows that many outpatient facilities in this country do offer good quality care, and they have surgery rooms that are fully equipped, properly staffed, and rigorously inspected. But we also know that too many cosmetic surgery outpatient facilities have spartan surgical settings, skeleton crews, no inspections, and no public accountability.

It is clearly time for reform. Comprehensive standards, peer review, and inspection programs are needed to improve the quality of outpatient cosmetic surgery. Most of these facilities lack accreditation, and that is one key area that has to be changed. Certainly, upgrading facilities so they can meet accreditation standards is more important to the patient than a massive advertising campaign.

Today, the subcommittee is going to be told that legislation is needed to put in place strong accreditation standards for outpatient cosmetic surgery centers. We will also be told that inspections and minimum Federal standards are needed to protect the cosmetic surgery patient. The Chair is pleased to have with the subcommittee two of the accrediting groups that have developed substantial programs to bring higher standards to outpatient facilities. I look forward to working with them and other health care providers to develop meaningful practical standards to protect consumers, standards that protect consumers but are fair to all the medical specialty groups.

There is one other issue that the subcommittee plans to examine today. That issue is the question of what constitutes a bona fide medical specialty board. Board certification, regarded by some as the Good Housekeeping Seal of Approval to the consumer, and a personal and professional goal for many physicians, seems to have been stripped of much of its real meaning. The distinction between a good specialist and a bad one is murky today at best. The American Board of Medical Specialties is here today to provide its views on the difference between its 23-member boards and the 105 alternative, often self-designated boards.

The Chair appreciates that all our witnesses share a common commitment with the subcommittee to provide quality, affordable, medical care. We are looking forward to their testimony.

Before I do recognize our witnesses, I want to recognize my friend and colleague, the gentleman from Missouri, Mr. Hancock, for any opening statement he cares to make.

Mr. **Hancock**. I don't have any statement at this time.

Chairman **Wyden**. Let us then go forward with our witnesses, Dr. Edward S. Truppman, president of the American Association for the Accreditation of Ambulatory Plastic Surgery Facilities and his associates, and let us recognize them first.

Dr. Truppman, and your colleagues.

[Witnesses sworn.]

Chairman **Wyden**. Gentlemen, let me ask you your intentions. Will each of you be making a statement or will one of you be making a statement for the entire group? What is your desire here today?

Dr. **Truppman**. Mr. Chairman, I am Dr. Truppman, and I will be making a final statement, Dr. Colon will be making a formal statement, and Dr. Singer, to my right, will be making a formal statement. Mr. Edward Stygar, the executive director of our organization will be available for any questions from the committee.

Chairman **Wyden**. Let me then, in the interest of time, because this is going to be a very busy day, ask that each of you three who are going to testify formally confine your remarks to 5 minutes each. That will allow, for presentation, 15 minutes for this panel and that should be sufficient. We will have each of you make a presentation of 5 minutes each.

Before we go forward with your testimony, though, let us recognize our friend from New York, Mr. Engel, who has been a very dedicated and a very good member of the subcommittee, for any opening statement that he chooses to make.

Mr. **Engel**. Thank you, Mr. Chairman. It has been an interesting morning, with all these votes.

Over the last 2 years, under your leadership, Mr. Chairman, the subcommittee has investigated trends in medicine and how they affect the quality and cost of medical care. None appears to me to be more obvious and more dangerous than the totally unregulated field of cosmetic surgery.

For centuries, doctors have quite rightly viewed their profession as a calling, a job with ethical and moral demands placing it above mere issues of dollars and cents, profit and loss. It is indeed unfortunate, however, that a few bad apples can spoil the barrel. We have found that most in the medical community are honest and ethical. But, in cosmetic surgery parlors, some have apparently viewed the almighty dollar as the only thing that counts.

Advertising techniques typically used for automobiles, beer, and cigarettes—outright hype and hucksterism—now pervade the cosmetic surgery business, and it is most obvious in the aesthetic surgery field. These ads don't serve the legitimate function of informing the public. Instead, they intentionally entice and deceive. They don't enhance the medical marketplace through increased competition; they victimize consumers in a cut-throat free-for-all.

I believe in competition, too, Mr. Chairman, but I think that advertising should give consumers information they need to make informed decisions. But there are two types of ads. There are those that identify doctors' credentials and the services they provide. But there are also those that blatantly seduce the unsophisticated, ads that lure them into the operating room. They give patients an implied warranty of safe, painless, and easy surgery that will make them happier and more successful people.

But when the FTC developed its laissez faire policy of anything goes advertising, and we saw that in our last hearing, most surgery was done in hospitals, under the watchful eye of peer review committees. But today, in cosmetic surgery alone, some 95 percent of the procedures, hundreds of thousands per year, are done in outpatient facilities, most of which are not inspected. Many of these pseudo-surgical centers don't even meet minimal quality control standards. Many don't even have basic life support equipment.

Mr. Chairman, I have real problems with the fact that there are no requirements for facilities where doctors do breast implants, tummy tucks, and liposuction. I think that most of my constituents would be surprised too, especially considering that my home town has almost as many cosmetic surgery parlors as it has delis, and you know there are plenty of delis in my home town.

I applaud the chairman for initiating this investigation, for telling the public about the risks they face, and for bringing the key players together to cure this problem.

Mr. Chairman, I look forward to joining you in introducing legislation to protect the American public from the few doctors who are more concerned about their own pocketbooks than their patients' safety.

Chairman **Wyden**. I thank my colleague for a fine statement, and look forward to pursuing these issues with him in the days ahead. I particularly appreciate his help with today's hearing on what is going to be a very, very hectic day, as we try to cover so much on the floor and in committee.

Let us then go forward with our witnesses.

Dr. Truppman, why don't we begin with you?

TESTIMONY OF EDWARD S. TRUPPMAN, M.D., PRESIDENT, AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC. [AAAAPSF], ACCOMPANIED BY EDWARD STYGAR, M.D., EXECUTIVE DIRECTOR

Dr. TRUPPMAN. I want to thank you, Mr. Chairman, for the opportunity to appear before you. As representatives of the American Association for the Accreditation of Ambulatory Plastic Surgery Facilities, or, as we refer to it, AAAAPSF, we appreciate the opportunity to express our perspective on the status of office-based surgery in the United States. Our Association was established specifically to assure patient safety in office-based surgical settings, and we have a broad data base on which we base both our concerns and potential solutions.

I would like to introduce the members testifying today. I am president of AAAAPSF and assistant clinical professor of plastic and reconstructive surgery at the University of Miami School of Medicine. Dr. Gustavo Colon, to my left, is vice president of AAAAPSF and clinical professor of plastic surgery at Tulane University School of Medicine. Dr. Robert Singer, to my right, is a member of the operating committee of AAAAPSF and vice chairman of the department of surgery at the Scripps Memorial Hospital, La Jolla, CA. He is also president of the San Diego Plastic Surgery Society. To his right is Mr. Edward Stygar, the executive director of AAAAPSF

It is currently estimated that 50 percent of all cosmetic plastic procedures are performed in doctors' offices. This trend toward office-based surgery was fueled by patients looking for cost savings and convenience. Since doctors operating in their offices were out of sight of the watchful eye of hospital peer review programs, and since no formal standards existed to govern these facilities, the possible dangers were obvious.

And plastic surgeons responded. In 1980, AAAAPSF was incorporated as an independent, not-for-profit entity, with the sole purpose of assuring patient safety in office-based plastic surgery. Although other organizations have since sponsored similar programs for medicine in general, AAAAPSF was formed at a time when the Government and consumers had yet to perceive the developing need. It has become the largest accrediting organization for office-based surgery in the United States, and has been recognized and recommended by both the American Medical Association and the American College of Surgeons. In addition, its standards have been endorsed by 90 percent of private insurance carriers. To date, we oversee 304 approved facilities, with another 128 in various phases of the rigorous accreditation process.

To apply for accreditation by AAAAPSF, the facilities must first, be owned and/or directed by physicians who are certified by the American Board of Plastic Surgery, or its Canadian equivalent; second, who have privileges to perform the same procedures in a hospital; and third, who adhere to a strict code of ethics. They must participate in peer review in a quality assurance program. They must display and adhere to a patients' Bill of Rights, and be governed in accordance with AAAAPSF standards.

Facilities applying for accreditation by AAAAPSF are evaluated in six primary areas: Patient selection and care, quality assurance, personnel, equipment, safety procedures, and plant design, and administrative documentation.

All inspectors are certified by the American Board of Plastic Surgery and own or direct an accredited ambulatory facility. We believe the fact that inspectors are drawn from the applicants' own specialty promotes the most thorough and meaningful examination.

To assure an objective, fair review, inspectors do not examine any facility located in their own community or that are staffed by a surgeon who served as an examiner for their own facility. The findings are analyzed by the most neutral, objective mechanism possible—the computer.

The final decision on the facility's application is made by the board of directors, and this may involve denial, provisional approval, or full 3-year accreditation based on the type of surgery performed.

Early in its development of the accreditation program, we recognized that differing levels of capability existed in office-based surgery facilities, and rightly so. To accommodate this reality, three classes of accreditation were established:

Class A—centers that perform only minor plastic surgery procedures using local, regional, or topical anesthesia.

Class B—centers that perform major and minor plastic surgical procedures using only intravenous or parenteral sedation, analgesia, or dissociative drugs.

Class C—centers that perform all types of plastic surgical procedures using all types of anesthesia, including general anesthesia. External support of vital body functions may be required.

As a caveat, operations in which major body cavities are entered on an elective basis may not be performed in any of these types of facilities.

Initially in the accreditation cycle, 40 percent of all applicants were approved for full accreditation in the appropriate classification; 55 percent were granted provisional status; and 5 percent were denied, and, as a caveat, two presidents of the American Society of Plastic and Reconstructive Surgeons and four members of our board of directors received only provisional approval on their first go around and had to correct the minor deficiencies.

The development and promulgation of national standards have inspired outpatient surgical facilities to make improvements prior to filing their application. As a result, first-time applicants are now showing fewer and fewer deficiencies.

Directions for the future. To build on the success of our program and extend it to other specialties, AAAAPSF last October proposed the following to the American College of Surgeons:

First, creation of a Council of Accreditation Associations for Unispecialty Ambulatory Surgical Facilities.

Second, development of tiered, generic standards for all unispecialty ambulatory surgical facilities.

Third, formulation of specific standards for each specialty when necessary.

At the present time, the American College of Surgeons is taking this under consideration for possible implementation.

In our 9 years of experience with evaluation of single-specialty ambulatory surgery facilities, we have observed a marked improvement in the quality of these centers. Fewer deficiencies are now evident among facilities who apply for the first time, as well as in those who seek renewal of their accreditation. We strongly believe this improvement is due to the development and implementation of voluntary, national standards for both the facility, and more important, the surgeons who operate them.

By making it possible for patients to safely visit outpatient plastic surgery centers, we offer them enhanced convenience and dramatic cost savings. Compared to hospital visits, the cost of office-based surgery is often 60 to 75 percent less.

As official representatives of AAAAPSF, we are here to assist the committee in finding a solution to the problem it has identified. We strongly believe that through our combined expertise, the patients and the public will be well served and protected.

Chairman **WYDEN**. Doctor, thank you very much.

[Dr. Truppman's statement, with attachments, may be found in the appendix.]

Chairman **WYDEN**. I don't think I followed who you would like to go next.

Dr. **TRUPPMAN**. Dr. Colon will be the second.

Chairman **WYDEN**. And then we will have——

Dr. **TRUPPMAN**. Dr. Singer.

Chairman **WYDEN**. Great. Very good.

Doctor, we appreciate it. We will put your remarks into the record in their entirety. I have heard my chairmen in the past say it very well—just talk to us. We will put your remarks into the record, so use your 5 minutes just to talk to us about your views on this.

TESTIMONY OF GUSTAVO A. COLON, M.D., VICE PRESIDENT, AAAAPSF

Dr. **COLON**. Well, Mr. Chairman, I do appreciate the privilege of being able to testify before you. It is often said that plastic surgeons are mute unless they have audio-visual slides. I have brought some slides just to sort of emphasize the point and show you some examples.

We are concerned about the unbridled proliferation of non-accredited surgical facilities that have been occurring throughout the country. We, as plastic surgeons, are particularly concerned in the growth because of unregulated office facilities which can pose a significant danger to the public, not only because of substandard conditions, but because some of these facilities are often owned and staffed by physicians with little regard for even minimum standards of patient safety.

I think it is important that the public be informed of the possibility of having selected a physician and a facility that lack the proper training, certification, peer review, with total disregard to ethics, safety, and responsibility.

It is not difficult for us to find physicians who have created facilities simply to perform procedures that they would not otherwise perform in hospital surroundings. We have seen situations—could somebody turn that slide projector on for me very quickly—in which physicians have office facilities which have been designed for a specific specialty but have used them for other specialties.

If we can turn the lights down just a little bit.

One example is a physician who advertises as a specialist in liposuction and cosmetic surgery in a facility that was actually designed as a birthing center and a birthing termination center. The tragic deaths of two patients undergoing liposuction in these clinics made news throughout the country.

Advertising, as we have all seen, is another way which unqualified physicians manage to build up a high-volume practice. One New York physician—and I am sure Mr. Engel has seen this in the New York Yellow Pages in the past or in the media. He was a trained plastic surgeon, not board certified, and conducted a very aggressive and deceptive campaign to build his cosmetic surgery practice. He subsequently served jail sentences for his offenses, with 212 malpractice suits pending against him, using an uninspected and unqualified facility with an unqualified staff. The doctor's only apparent concern at this time was how many patients he could run through his cosmetic surgery mill.

More recently, we have seen in the papers over the last several weeks a patient undergoing breast augmentation who died because of an overdose of anesthetic drugs in an unaccredited outpatient surgical facility.

As a student of medical history, charlatanism, entrepreneurism in plastic surgery has been around for a long time. In the 1920's, these physicians called themselves featural surgeons. Their letterheads promoted facial rejuvenation, featural contouring, and decorative surgery. Since 1978, physician advertising has mushroomed and plastic surgery has been harder hit than any other medical specialty. Ads for plastic surgery, as you can see on the right, range from the ridiculous, to the sensational, to the clearly fraudulent.

Advertising is supposed to decrease the cost of medical care to the consumers by increasing competition, as perhaps stressed by the Federal Trade Commission. We don't believe that this is true. We have seen where there are cases where the cost of excessive advertising campaigns necessitate increased patient turnover, internal cost-cutting which affects the quality of the facility and the services, the use of inappropriate staff, and occasionally the operations on the wrong type of patient.

When the triangle of morality, ethics, and professionalism which represents the guiding principles in all professions, particularly medicine, is overturned by greed, the patient is always the one who suffers.

Office surgery, despite the expense of maintenance and even promotion, has the potential to create significant income for the physician who operates his own facility. This is part of the attraction to the untrained physician to perform surgery in an unqualified facility, motivated by self-interest, greed, and fueled by relentless self-promotion, and you get the ugly triangle of hucksterism—which is misspelled—unnecessary surgery and unqualified facilities which has been pushed by greed and advertising.

While no surgery is risk free—you may turn the lights on now, if you wish—problems can arise even when the surgeon is highly qualified and the facility meets all reasonable standards.

We strongly believe that steps must be taken to establish and maintain national standards for accreditation of office surgery facilities and that accrediting organizations such as those before you today must be recognized to assist this effort.

The public must be better educated about first, the risk of surgery; second, the meaningful qualifications of the surgeons; and third, the importance of facility accreditation.

The Federal Trade Commission must also do its part to protect the medical consumer. It must stringently enforce regulations governing truth in advertising, give special attention to eliminating false and misleading advertising in the plastic surgery arena.

Without swift and thorough action on the part of the appropriate agency, many, many more innocent people will be victimized by greedy, unscrupulous physicians falsely bearing the title and mantle of plastic surgeons and taking refuge in unaccredited and substandard office surgical facilities.

Thank you very much.

Chairman WYDEN. Doctor, thank you very much.

[Dr. Colon's statement, with attachments, may be found in the appendix.]

Chairman WYDEN. Dr. Singer.

TESTIMONY OF ROBERT SINGER, M.D., MEMBER, OPERATING COMMITTEE, AAAAPSF

Dr. SINGER. Chairman Wyden, I appreciate the opportunity to be present here today and address this congressional committee.

As surgeons and plastic surgeons, our goals are to provide the highest quality of patient care, while keeping costs reasonable. This latter mission is being fulfilled quite successfully as technology allows an increasing number of procedures to be performed in doctors' offices.

However, as you have heard in my colleagues' testimony, the potential for substandard care is very real. It is apparent that national standards governing these office-based surgical facilities are essential if our first goal, patient protection, is to be fulfilled. Perhaps nowhere is this more true than in the specialty of plastic surgery.

As physicians from a wide variety of fields rush to practice the specialty perceived as being fast growing and lucrative, the doctor's office can become a haven, free from outside scrutiny. It has and will be stated by others that attempts to regulate the facilities where plastic surgery procedures are performed as well as the physicians who perform them is no more than a turf battle. If this so-called turf concerns patient protection, safety, adequate surgical training, morality, and medical ethics, then we agree it is a turf battle. This is, however, the only turf with which the AAAAPSF is concerned.

Office-based surgery in this and all other specialties is largely unregulated. The Health Care Financing Administration has developed criteria only for outpatient facilities located in hospitals or free-standing multispecialty centers. Yet our statistics show that 50 percent or more of plastic surgery procedures are performed in doctors' offices. We recommend this appalling lack of quality control be remedied with the following actions.

One, develop national standards governing both the office-based surgical facilities and the surgeons who practice there. These standards should consist of a core of generic criteria that is applied to all types of ambulatory surgery, not just plastic surgery. The standards should address patient monitoring, equipment, emergency response procedures, administrative policies, and appropriate facility design criteria for unispecialty office-based surgical facilities.

In addition, a subset of specific criteria for each surgical specialty should be developed to reflect the individual needs and potential problems unique to that particular field. Both generic and specific standards should be tiered according to the type of anesthesia used by the facility and the scope of the procedures performed. They should be updated periodically and require onsite inspections at regular intervals, assurance that the surgeons practicing there have privileges to perform the same operations at a local hospital. Appropriate levels of nonphysician staffing, participation in a peer review and quality assurance program, display of and adherence to a patients' Bill of Rights, and thorough documentation of each procedure performed.

The second recommendation is that these standards be enforced on a mandatory basis. This can be accomplished by existing nationally recognized accrediting organizations which have already developed excellent evaluation criteria and accumulated an impressive track record. These organizations are the American Association for Accreditation of Ambulatory Plastic Surgery Facilities (4a), our organization; the American Association for Ambulatory Health Care (3a); and JCAHO.

Using these existing organizations to enforce standards for office-based facilities will avoid the necessity for additional bureaucracy, manpower, and funds. To harmonize the efforts of these various accrediting organizations, an umbrella group such as the American College of Surgeons could serve as overall coordinator. The AAAAPSF stands ready to assist any such umbrella group, whether it is private or governmental, in developing accreditation guidelines. In fact, we have already made this offer to the American College of Surgeons.

If an office-based facility cannot reach these reasonable standards, it would not be safe to undergo a procedure there. Surgery in that center should not be allowed, whether it is a plastic or any other type of surgical procedure.

Three, mandate peer review for physicians practicing in office-based facilities, whether through accreditation or extension of section 1832 of the currently existing Federal law governing Medicare-approved centers. That law already requires peer review and allows physicians to perform only those procedures in their facility for which they are authorized to perform in a hospital located in their area. To date, HCFA has not applied this portion of the law to office-based surgical facilities.

Appropriate training for physicians practicing in these facilities must be defined. It is the physician, hopefully a surgeon, who operates, not the facility. Appropriate training, as I emphasized before, must be defined and required. The physicians should be able to demonstrate adequate training and obtain corresponding privileges in an accredited community hospital.

Four, require malpractice insurance for physicians operating in their offices.

Five, ensure truth in advertising by requiring full disclosure of the physician's training and limiting claims of board certification to those physicians certified by organizations recognized by the American Board of Medical Specialties. In addition, those doctors who are allowed to make this claim should be required to state the full name of the board that certified them.

Six, implement these mandates through national legislation and/or model statutes for States.

In summary, the solutions I have outlined will protect the public to the fullest extent possible by ensuring a safe environment while, at the same time, containing costs. We plead with you to help us return order to the currently chaotic and potentially dangerous state of cosmetic office-based surgery. As the first professionally organized accrediting program established solely for these facilities, we welcome and encourage peer review, quality standards, and accreditation for all ambulatory office-based surgical centers.

Thank you.

Chairman **Wyden**. Doctor, thank you.

[Dr. Singer's statement, with attachments, may be found in the appendix.]

Chairman **Wyden**. Let us see if we can at least begin the questioning.

What is the best estimate of how many outpatient cosmetic surgery facilities there are in this country, doctor?

Dr. **Truppman**. We don't have exact statistics on this by board certified plastic surgeons, and we have just funded a study. Our last study is approximately 8 to 10 years old. At that time there was an estimate of about 700–800 facilities, which half of them were A-type facilities, and whether those need the strict accreditation standards or not, that is a point of debate. But certainly a B and C facility need it.

At the present time, we feel that we are probably certifying, or accrediting I should say, approximately 50 to 60 percent.

Chairman **Wyden**. But my question is how many overall cosmetic surgery outpatient facilities are there according to our best estimates? I understand, for example, the minimum figure is probably 5,000. Is that correct?

Dr. **Truppman**. That is probably correct; yes, sir. But, if you are narrowing it down to board certified plastic surgeons——

Chairman **Wyden**. No; that is not what I asked.

Dr. **Truppman**. OK. All right.

Chairman **Wyden**. But you agree that overall there are probably at least 5,000 cosmetic surgery outpatient facilities in this country?

Dr. TRUPPMAN. I think that would be a reasonable estimate; yes, sir.

Chairman WYDEN. As of now, the vast majority of these programs are not part of any accreditation program.

Dr. TRUPPMAN. That is true.

Chairman WYDEN. What, in your view, are the characteristics of an outpatient cosmetic surgery facility that could represent specific problems for consumers? We know that there are many very good ones, but there are clearly certain things that could represent problems for patients such as, for example, the lack of basic equipment. Could you briefly just go through what you think are the common characteristics of a cosmetic surgery outpatient facility that could cause problems for a consumer?

Dr. TRUPPMAN. I will let Dr. Colon answer that.

Dr. COLON. May I show you an example? I can tell you very quickly what we think is wrong. First of all, one of the things that we find that can occur and might occur is where an examining room becomes an operating room at a certain time of the day. In other words, it is an examining room one day and maybe an operating room the next day.

Individuals who don't have the proper training—rather than having nurses or technicians who are trained in operating room techniques, they may use somebody from the office as a means of cutting the costs.

These are the things that we are concerned about. What we want is qualified facilities that meet the standards of sterility and safety of operating rooms with the appropriate personnel. We think that in some of these, if not many of these, these standards are not being met.

Dr. TRUPPMAN. Just as an example—God forbid it ever happens—the power goes out. The patient goes into a cardiac arrest, respiratory arrest, and what do you do? They have to demonstrate that they can resuscitate the patient in a timely manner. They have backup for their power failure. They are able to transfer the patient to a facility after the patient's been stabilized, et cetera. We run through the—excuse the expression, after Tiananmen Square—the Chinese fire drill routine to make sure that they can handle these type of emergencies. That is a part of what we do when we go in there, and we want to make sure that it is like a computer. You have software and hardware. If the hardware is OK but the software doesn't work, you are not going to have a decent product.

Chairman WYDEN. Of the 5,000 minimum number of facilities we have in this country, do a substantial number lack those kind of backup-support systems that you are talking about?

Dr. TRUPPMAN. Yes.

Chairman WYDEN. Any figures on how many there are?

Dr. TRUPPMAN. No.

Chairman WYDEN. But a substantial number?

Dr. TRUPPMAN. Unfortunately, yes.

Chairman WYDEN. So, we are talking about personnel. We are talking about equipment—that an examining and operating room may be appropriate based on the equipment they have. We are talking about backup systems.

Are there any other factors that on a regular basis would represent concern for consumers? You mentioned peer review, didn't you?

Dr. **Colon**. Yes; peer review and the ability to transfer patients to hospitals, for example. Should something go wrong, and it can happen even in a good facility, you must have the ability to admit patients to hospitals should the emergency arise. We feel that all of the staff should be trained in cardiopulmonary resuscitation. We feel that any emergency that can come up in an operating room, you should be prepared to handle in your office if you are a B or C facility. If somebody goes to sleep in your operating room, you better be able to take care of any emergency that can occur in that operating room.

Chairman **Wyden**. Gentlemen, we have a vote on the floor. We will go make the vote, but first, I want to recognize my colleague, Mr. Hancock.

Mr. **Hancock**. The majority of the surgeries that we are talking about are elective-type surgeries. Am I correct?

Dr. **Colon**. Yes, sir.

Mr. **Hancock**. Dr. Colon mentioned education. It seems to me like the doctors on television always win. I wonder if we should better educate people that any type of surgery is serious, that complications can arise. I wonder if maybe some in the profession are a little too quick to say, "Well, yes; we can take care of everything." At least they give the impression to people that they can take care of any little problem.

Dr. **Singer**. I think that the emphasis from the ethical, well-trained, board-certified surgeon in discussing surgery with his patients or when in the media, as you mentioned, their role has been to try to educate that this is real surgery. There are real potential problems. This is not like going to get your hair cut, and there is a risk/reward. This surgery is not for everyone.

In the hands of a well-trained, fully certified surgeon, the probability of those problems will fall. He still may have problems in the best of hands. There may be some complications. But a well-trained surgeon will be able to anticipate the problems, avoid them, select the patients, and if he gets in trouble, hopefully get out of trouble and correct the problem later.

So, I believe it is the role that all of the good, ethical surgeons take to help educate the public to that reality.

Dr. **Truppman**. In the State of Florida, which is the worst malpractice State in the country, I am secretary of the largest malpractice trust there. We emphasize to all surgeons that they must explain to every patient the realistic expectations of the surgery, the alternatives, and the risks. If you don't do that, you are not fulfilling your legal and moral obligation to a patient, whether you are taking out an appendix or fixing a nose.

Mr. **Hancock**. But the fact remains there are a lot of doctors who, as the statement was made, maybe are a little greedy.

Dr. **Truppman**. That is true.

Mr. **Hancock**. Thank you.

[Recess.]

Chairman **Wyden**. The subcommittee will come back to order.

Dr. Singer, you, in your statement, strongly endorse the need for a mandatory national accreditation program for cosmetic surgery outpatient facilities. I gather your view is that the voluntary system simply doesn't work at this point.

Dr. **Singer**. That is correct.

Chairman **Wyden**. Could you tell us why it is your view that a voluntary approach will not deal with this field that is undergoing such enormous growth?

Dr. **Singer**. The unfortunate reality is that there are many individuals who call themselves plastic surgeons who are inadequately trained, and there are some bad actors who are well trained, and those individuals aren't going to be coming forward and be willing to take an examination or have their facility inspected. So, to have safeguards and guidelines, you need to have a more rigid system that will evaluate all of that.

Remember, that with the change in the situation to outpatient surgery some of these or many of these physicians who would not ever have been able to operate and get privileges in a hospital have now escaped to their office and there is no adequate guideline to evaluate them today. So, we need that.

Chairman **Wyden**. Would your organization support Federal legislation to address some of these minimum criteria that an outpatient cosmetic surgery facility should have, such as minimum criteria for equipment, and life-support systems, and the like, doctor?

Dr. **Truppman**. Yes.

Chairman **Wyden**. The answer is your organization would support Federal legislation?

Dr. **Truppman**. Yes.

Chairman **Wyden**. In terms of your own program, your own inspection and accreditation program, I would like to see what areas you all have minimum standards in. Do you have minimum standards for equipment in your program?

Dr. **Truppman**. Yes.

Chairman **Wyden**. Microphones can't record a nod, folks.

Dr. **Truppman**. OK. Instead of minimum standards. I would rather use appropriate standards.

Chairman **Wyden**. I understand. I just want to be able to know exactly what you have.

Dr. **Truppman**. The answer to that question is we do have appropriate standards for equipment, monitoring equipment, plant, design, sterility, traffic flow pattern. I can go on for an hour and a half, if you would like.

Chairman **Wyden**. Let's go one at a time. You all then have standards for equipment?

Dr. **Truppman**. Yes.

Chairman **Wyden**. You have standards for personnel?

Dr. **Truppman**. Yes.

Dr. **Colon**. Yes.

Chairman **Wyden**. You have standards with respect to emergency backup systems?

Dr. **Truppman**. Yes.

Chairman **Wyden**. You have standards with respect to evacuation or transportation to the hospital?

Dr. **Truppman**. Yes.

Dr. Colon. Yes.

Chairman Wyden. Do you have standards with respect to recordkeeping?

Dr. Truppman. Yes.

Chairman Wyden. Standards with respect to peer review?

Dr. Truppman. Yes.

Chairman Wyden. How about internal quality controls?

Dr. Truppman. If you would like, I will read into the record, although you have it under our General Standards and Facility Classification.

Group practice plastic surgeons shall periodically review random cases and cases with complications at least quarterly. These meetings shall be properly documented. For solo practitioners with a plastic surgical facility it is suggested that a review committee be formed with members of the plastic surgeons section of the medical staff of the hospital at which he or she holds admitting privileges for the purposes of periodically reviewing random cases or cases with complications. If this is not feasible, some similar organization of local plastic surgeons be established for the purpose of peer review. These meetings shall be properly documented.

If you cannot do that, we recommend that you join a regular PRO group.

Chairman Wyden. Your program also reviews a physician's credentials to ensure that they have the training that they purport to have?

Dr. Truppman. That is correct.

Chairman Wyden. Are there any other areas, any other major areas where your organization has adopted standards?

Dr. Truppman. Sorry?

Chairman Wyden. Are there any other major areas such as the ones I have touched on where your organization has adopted the appropriate standards?

Dr. Truppman. Dr. Singer wants that.

Chairman Wyden. Doctor.

Dr. Singer. Yes; part of the standard is evaluation of the individual's adherence to a code of ethics, and that takes us into the arena of false and deceptive advertising. The individual who falsely and deceptively advertises would not be able to get accreditation through our program.

Dr. Truppman. We do other things too. Dr. Colon and myself, twice a year, at the major meetings hold courses of 4 hours each, going through all the requirements for accreditation, and what is good, and what is bad, what is new, and what is going on in the area, and we are very well attended at these seminars. So, this is another way of educating the plastic surgeons as to what they should and shouldn't have in their office facility.

Chairman Wyden. You also have standards, I understand, with respect to patient selection.

Dr. Truppman. That is correct. We strongly recommend that only anesthesia risk classification I and II, or, in other words, healthy patients or patients with very mild systemic disease, be operated on in these facilities. If you operate on a healthy patient, you are more likely to have a healthy patient walk out of your office.

Chairman WYDEN. Let me ask you—yes; go ahead, Doctor.

Dr. COLON. I just wanted to make one comment. You talked about recordkeeping. We put into the record an example of the type of recordkeeping that we ask that our facilities have. We expect all patients to have the same type of workup that you would do to any patient who is going to undergo surgery within a hospital system.

Chairman WYDEN. Gentlemen, or maybe I will direct this to you, Dr. Truppman. Are you familiar with the clinical laboratory legislation that was passed last year, the CLIA bill?

Dr. TRUPPMAN. I am not as familiar with it as our executive director, Edward Stygar is, and he, I am sure, can answer any questions you may have in that area.

Chairman WYDEN. Is he here? Oh. Excuse me. Yes; my apology. Doctor, are you familiar with the basic scope of the CLIA legislation?

Dr. STYGAR. Yes; I am.

Chairman WYDEN. As you know, I was very involved in rewriting that legislation, working closely with Chairman Dingell and Chairman Waxman. Now Dr. Truppman has said today that he believes Federal legislation will be necessary to deal with some of the issues we have been examining in the cosmetic surgery field, particularly with respect to outpatient procedures.

Is it your view that the CLIA bill, as written last year, which would update what we are doing, would serve for the most part as a pretty good model for how we might proceed with Federal legislation in the cosmetic surgery area?

Dr. STYGAR. Yes; with appropriate modifications for surgery.

Chairman WYDEN. Why don't you outline, then, briefly what you think might be the areas where we should look to the CLIA model for drafting legislation and what areas we might pursue in a somewhat different way?

Dr. STYGAR. Well, I think the basic things that you have within the CLIA Act, based on the quality assurance standards, personnel, appropriateness of the selection of tests, things like that, and who does what, are still appropriate to surgery. Because you still need those basic standards for the facilities, for the personnel, for the procedures, even though they are a little bit different.

The difference would be in the selection process of those procedures to ensure that there would be appropriate personnel once again, not only from the standpoint of the operating personnel, but I believe from the surgeons, just as you have made distinctions within CLIA over the years, and I think that would go on to serve ambulatory surgery. The other distinction I think you really have to make is that between an ACS—an ambulatory surgery center—and that of office-based surgery, because that distinction hasn't been made by the Government. They lump it all in one. So, you are going to have to step it down similar to our standards with the A-, B-, and C-type facilities.

Chairman WYDEN. Does the gentleman from New York have any questions he would like to ask at this time?

Mr. ENGEL. Thank you, Mr. Chairman.

I would like to ask any of you who might care to answer—over the past decade, peer review—we talked about peer review—has come under attack as being anticompetitive, and I am wondering how you feel about that. Do you feel that peer review over outpatient facilities can avoid charges of collusion, and, if so, how?

Dr. **Truppman.** Yes; I think that it can, and we, again, don't want to get involved in a so-called turf battle because the turf battle here is patient safety, and health, and a properly done procedure. The anticompetitive nature of this is no more anticompetitive than the requirements that the bar has in various States, that we have for medical licensure, that we have for various and sundry other situations of training to make sure that the public is protected. I think we have to walk that fine line between anticompetition and protecting the Government's public health and safety. Sometimes that is a fine line.

We find governmental agencies restricting by certificate of need certain facilities. In a way that is legislative monopolies or anticompetition. We are not for that sort of thing. We are for free competition in the medical health care delivery field.

Mr. **Engel.** If we raise the operating costs of previously unaccredited centers to get them into compliance, won't that increase the pressure on these centers to advertise and operate on more patients and put a burden on them to just do the very thing that we want to get away from?

Dr. **Truppman.** No; I really don't think that will because the cost of these facilities—for example, getting accredited in our facilities runs $450 a year. That is certainly not onerous or burdensome. That is because all of our inspectors are voluntary. They don't get paid transportation. They don't get paid for lunch. They don't get paid anything, so we can keep the cost down, to the Government, to the patients, to the facility being inspected. So, I don't think that is where the cost goes up.

But when you get into advertising campaigns of hundreds of thousands of dollars for an individual surgeon, that, indeed, is going to be passed on to the patient.

Mr. **Engel.** If someone seeks accreditation from the AAAAPSF, how much does that cost to get accredited?

Dr. **Truppman.** $450 a year.

Mr. **Engel.** $450 a year?

Dr. **Truppman.** Yes.

Mr. **Engel.** If it is so inexpensive, why do you feel that so few clinics are seeking accreditation? Is it because that they do not need the accreditation?

Dr. **Truppman.** Dr. Singer is just chomping at the bit to answer that one.

Dr. **Singer.** The reason that so few facilities have sought this is, first of all, it wasn't required. Second, there are many physicians outside of the normal pathways of medicine who would not be able to get accreditation; there are some who cut costs. In addition, there are many plastic surgeons who do the bulk of their surgery as reconstructive surgery. This becomes a catch 22 since insurance companies generally haven't reimbursed for outpatient surgery. So, they don't have the incentive to get accredited unless there would be some reimbursement from a third party for reconstructive procedures. If that existed, and there was a good accreditation program nationwide, then we would see more people willing to get accreditation. At that point you would have a marked cost containment because the procedures which now could be done safely in an outpatient facility and are being done in the hospital would shift to the outpatient facility.

Dr. TRUPPMAN. Another answer to that, Mr. Engel, is that in the Omnibus Medicare Reform Act of December 1980 they were instructed to pay for facility costs for office surgery. It has been almost 9 years, or 8 years now since that has been passed and HCFA has yet to implement this portion of the law. We have been up, as AAAHC has been, trying to get them to implement this aspect of the law because the savings to the Federal Government in 1984 would have been many billions of dollars a year by encouraging this, and we have yet to discern what the motivation was of HCFA not to implement this aspect of the law.

Dr. COLON. You spoke about advertising. One of the things that we stress in our teaching courses is that office surgery is a service to your patient population. It is not a means of attracting patients into your practice, because the costs can be overwhelming in building one of these facilities. If you do not have the patient population to support an office surgical facility, then perhaps you should not have one. Because then you will be taking out of one pocket and putting it in the other, so, you have to do it as a means of servicing your patient population.

Mr. ENGEL. At the last hearing we had, Chairman Oliver of the FTC testified in front of this subcommittee the fact that complaints against false advertising are on the decline. He said that this indicated that the problem is subsiding.

Do you believe that false advertising is an ailment that is curing itself?

Dr. TRUPPMAN. No.

Dr. COLON. No; it is not.

Dr. SINGER. I think it is greatly on the increase.

Mr. ENGEL. Let me just ask one other question. I have a lot, but let me just ask one other question. Are there any cosmetic surgical procedures that you feel may be performed safely by physicians who are trained in specialties other than plastic surgery?

Dr. TRUPPMAN. Yes.

Mr. ENGEL. Can you tell us what those are?

Dr. TRUPPMAN. I think that the American Board of Otorhinolaryngology includes in its specialty facial plastic surgery; in other words, surgery done above the level of the clavicle, in the head and neck area, and I think there are some very well trained and fine surgeons in this area doing this type of surgery. Dermatologists do excellent work in the form of certain facial peeling and in the form of hair transplants.

These are areas that have been traditionally in these specialties, and we certainly feel that there is overlap in specialties just as there is between neurosurgery, and orthopedic surgery, and back surgery, just as there is hand surgery between plastic surgeons, general surgeons, and orthopedic surgeons. We are not criticizing this at all.

Mr. ENGEL. Let me just ask one more along the lines of some of my earlier questions. If we impose national standards on surgery, it would seem to me that it could force many doctors out of cosmetic surgery. Would this exodus from the field help or hurt consumers? Obviously, we want the unscrupulous ones out. But my concern, on the other hand, would be, if we are restricting competition, and therefore making this almost an elitist group that can perform it, are we not doing consumers a disservice?

Dr. TRUPPMAN. Well, I don't look upon myself as an elitist, but I am dedicated to quality surgery. Yes; I think that you don't need a 16-inch cannon to treat this problem. I think it is carefully tailored legislative action to assure that units are inspected and accredited by nationally recognized accreditation organizations, legislation to assure that people do not represent themselves as something they are not, as recognized by medicine establishment organizations such as the American Board of Medical Specialties. A very articulate person can come in and can con nonsurgeons. But it is very hard to con your colleagues in surgery, and you can find out who they are sending their family to, to have this type of surgery done, and I think you will be protected. But not every consumer is able to do this, and, consequently, I think it is up to the evaluation, which is dynamic and changing every year; what may be improper this year may be proper next year. I think that if this were under the umbrella of an organization, as we said, such as the American College of Surgeons, I think this would be excellent and would cure the problem.

Mr. ENGEL. Let me ask you, Dr. Colon, you said in your statement that if a doctor spends $100,000 a year on ads that he would need an income of $200,000 just to break even. Enlighten us as to what shortcuts do these operators of cosmetic surgery mills take to squeeze the most profit out of their practices and patients.

Dr. COLON. What I was saying was that, if you have an advertising budget of $100,000 a year and you have an operating budget of 50 percent of your practice, you are going to need another $100,000 to maintain your staff. So, you are going to need $200,000 at least to pay for the cost of advertising plus overhead. What happens then is, if you have got such a high overhead, and you don't have the patient volume to support your operating facility, that 300-pound diabetic woman who shouldn't have liposuction, all of a sudden becomes a candidate for the operative procedure, and somehow, the quality of surgery begins to be—well, you can say it is broadened to a certain extent, and you may be operating on patients who you otherwise would not operate if you did not have that big overhead nut to crack. This is the one thing that we are trying to stress. If you have the patient volume you can do the surgery.

You said before that if you increase your standards are you going to exclude some individuals. Well, I think you are going to shake the tree, and those who have weak bases for office surgery will fall out, but those who have strong office facilities, that are primarily concerned about patient care quality, they will stay in the business. Those are the ones that the patient should go to.

Dr. TRUPPMAN. In our courses we stress not only informing the patient as to expectations, alternatives, and risks, but also the fledgling plastic surgeon going into this sort of field, you have certain expectations, alternatives, and risks, both economically and in professional liability areas. They have to be informed of this also before going into it.

Dr. SINGER. Remember that in the name of competition the FTC opened this Pandora's box. The medical specialties and the medical societies had done a fairly good job of policing itself. I can speak certainly for California. We were fairly free of problems in plastic surgery until the change with the FTC rulings, and the FTC ruling had essentially maintained that we, as plastic surgeons in the plastic surgery society, had unduly high standards for plastic surgery. When you look at that, what does that really mean? Unduly high to whom? I doubt it would be unduly high for their family members, and it certainly wasn't unduly high for the specialty. I doubt that you would think today with where we find ourselves that those standards were unduly high for the patient population and the consumer. What we are saying is we should go back to having adequate standards.

Mr. ENGEL. The fact that most of the surgery is done in outpatient facilities, obviously, from your testimony and everything I have read, contributes greatly to the problem. Is that not a fact?

Dr. TRUPPMAN. Yes.

Dr. COLON. Yes.

Mr. ENGEL. We mentioned the $100,000 figure. I don't know if that is a figure that you just used to demonstrate, but would you say that is a fair amount that many of these people spend?

Dr. COLON. Oh, that is a low amount. I think that what I put in was just a fictitious figure to give an example, but I think it is easy, as you saw from what I showed you today, in 1 year that physician was spending $1.8 million. If you look at some of the ads that we are seeing today, these ads are not inexpensive, and some of these individuals are spending over $100,000, $200,000, $250,000 a year, and to be perfectly honest with you, marketing people will come to you and tell you that they can increase your volume and your practice, and they will help you, and this is part of it, and this is not inexpensive. Nor is their fee.

Dr. TRUPPMAN. It also contributes to the medical malpractice problem because you have patients coming in who are unsophisticated, frequently with unrealistic expectations.

Dr. SINGER. What we are advocating is really no different from the standards that are already in place for other health care providers, in the sense of hospitals or laboratories. There are inspections and standards, and many of these facilities are minihospitals. They function that way, so there should be an appropriate regulation. We want to see the physician have some peer review and scrutiny. They have escaped that by being able to open a facility, get out of the peer review mechanism of a surgery supervisory committee in the hospital, and now they can advertise and attract patients. So, they have circumvented the whole system.

Dr. TRUPPMAN. The other side of that coin is, that is, in Medicare, some of—when we had certificate of need in Florida, an individual in Miami put up a facility that cost a half a million dollars, which was a beautiful facility, and had to spend another half a million dollars complying with architectural design, so on and so forth. What happens is we don't want to make these requirements so onerous as to add to the cost so greatly that these services are no longer affordable by middle-class America.

Chairman **Wyden**. Would the gentleman from New York yield?

Mr. **Engel**. Yes.

Chairman **Wyden**. Doctor, your program uses a 3-tiered approach, as I understand it, to distinguish between facilities offering minor procedures, something I think along the lines the gentleman from New York is concerned about, from those doing major procedures that would have to meet more stringent requirements. You base the classes of facilities, as I understand it, on the type of anesthesia used. After that was done, your next step was to develop a list of procedures that are best and most safely performed using each type of anesthesia. Is that correct?

Dr. **Truppman**. That is correct.

Chairman **Wyden**. Now that is not all that different from the concept, again, under the CLIA legislation that allows for incrementally less stringent requirements based on the complexity of the test all the way to the point of allowing a waiver when the test has an insignificant risk and an erroneous result. Is that your understanding as well, Doctor?

Dr. **Truppman**. Yes.

Chairman **Wyden**. I thank the gentleman. I think the gentleman from New York is asking about a very important point because clearly one does not want to layer on regulation disproportional to risk. It is my view as we examine the CLIA legislation in particular with an idea to determine whether it might be applicable to cosmetic surgery facilities, that ensuring that we do not do what the gentleman from New York is talking about is essential. You have to put in place standards that are commensurate with risk, and to do otherwise would hamper our joint objective.

Doctor.

Dr. **Stygar**. May I make one additional comment? You have to remember that it is not only plastic ambulatory surgery, but it is all of ambulatory surgery, and there is becoming a big shift, and the shift is going from the hospitals, and it is into ambulatory surgery units, and most of it is going to be done in office surgery units, rather than the ACS—the ambulatory surgery centers.

There is a distinction there that has to be watched. Because the insurance companies today are starting to encourage that by paying more to those doing it outside, the 100 percent versus 80 percent, for instance, for the facility costs and things like that. You just have to be a little bit cognizant of that fact so that we don't misplace some of these things because office surgery is going well beyond everything that even—just as cosmetic surgery, it is going into all the specialties.

Chairman **Wyden**. I thank the gentleman from New York for yielding. Any additional questions, Mr. Engel?

Mr. **Engel**. I have no more questions, Mr. Chairman.

Chairman **Wyden**. We want to thank all of you. You have been most cooperative, and we are going to be in touch with you often in the days ahead as we look to trying to pull together the various medical specialty groups in an effort to strengthen standards in this area. We appreciate your views today, and we will be in touch soon.

Dr. TRUPPMAN. We wish to thank you and commend you on your effort to protect the public safety.

Chairman WYDEN. Thank you very much.

Chairman WYDEN. Our next panel is Dr. Carl Battaglia, president of the Accreditation Association for Ambulatory Health Care and Ronald S. Moen, executive director, Accreditation Association for Ambulatory Health Care.

Gentlemen, we welcome you. I think by now you are aware of the rules of our subcommittee. Do you have any objection to being sworn as witnesses today?

Dr. Tobin, you have arrived at the witness table as well. Let us take you on a third panel after Dr. Battaglia and Mr. Moen. We appreciate your patience as well.

Gentlemen, you have no objection to being sworn today?

[Witnesses sworn.]

Chairman WYDEN. Gentlemen, is it your desire to each make an opening statement, or will one of you represent your organization?

Dr. BATTAGLIA. Mr. Chairman, I am aware of the subcommittee's time constraints. I will make a formal, 7-to-10-minute presentation, and then we will both be available for questions from the subcommittee.

Chairman WYDEN. Very good. We will make your prepared remarks a part of the record in their entirety, and if you could as well just speak to us and tell us of your views, that would be helpful.

Dr. BATTAGLIA. Thank you, sir.

TESTIMONY OF CARL BATTAGLIA, M.D., PRESIDENT, ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE [AAAHC], ACCOMPANIED BY RONALD S. MOEN, EXECUTIVE DIRECTOR, AAAHC

Dr. BATTAGLIA. My name is Dr. Carl Battaglia. I am the president of the Accreditation Association for Ambulatory Health Care and a practicing anesthesiologist at the Texas Outpatient Surgi-Care Center in Houston, TX. Accompanying me this morning is the executive director of the Association, Mr. Ronald Moen, from Chicago.

The Accreditation Association for Ambulatory Health Care, which we will refer to as AAAHC henceforth, is pleased to respond to your invitation to present this testimony before the subcommittee concerning the accreditation of office-based cosmetic surgery practices. AAAHC's history spans nearly 20 years. The Association currently has 10 members which are national trade and professional associations that represent a wide variety of organized health care delivery systems.

AAAHC accredits a wide range of ambulatory care facilities including, for example, ambulatory health care clinics; ambulatory surgery centers, commonly called ASC's; birthing centers; college and university health services; community health centers; dental group practices; faculty medical practice plans; health maintenance organizations, or HMO's, and other prepaid or managed care systems; hospital-sponsored ambulatory care clinics and surgery centers; multispecialty group practices; occupational health services;

office surgery centers and practices; single specialty group practices; surgical recovery centers; and, finally, urgent and immediate care centers.

As you have heard in previous testimony, Mr. Chairman, over the past 10 years, outpatient surgery has grown more quickly than virtually any other sector of the health care marketplace. This trend toward the performance of surgical procedures on an outpatient basis is caused by a number of factors. Advances in technology now make it possible for over 50 percent of all surgical procedures to be safely and cost effectively performed on an outpatient basis. Outpatient surgery, as you have already heard, is also more convenient for patients, more efficient for physicians, and more cost effective for the Government, third-party payers, and patients.

Today, there are almost 1,000 Medicare-certified ASC's. SMG marketing data suggests that approximately 9.2 percent of the procedures performed in ASC's in 1988 involved plastic surgery. In addition, preliminary results of the SMG marketing group study suggest that about 7 percent of the Nation's 12 million outpatient procedures take place in physicians' offices.

AAAHC's accreditation program has only reached a small minority of ASC's and office-based surgical centers. At this time we have accredited approximately 350 facilities, including 112 ASC's and approximately 44 office-based surgery centers and practices. Of the office-based practices, 19 are either facial or plastic facilities. However, there continues to be a growing interest among specialty practices in having their organizations accredited, especially among office surgery practices and ASC's.

AAAHC's standards are extremely comprehensive. The minimum initial survey of an organization seeking accreditation is 1½ days and involves at least two physician surveyors. The survey team for an office-based cosmetic practice would be drawn from a surveyor pool consisting of anesthesiologists, plastic surgeons, facial plastic surgeons, and general surgeons. The formal accreditation decision is made by the accreditation committee, a multidisciplinary group of physicians, including a plastic surgeon who this year chairs that committee.

A number of the standards included in AAAHC's survey process may be of particular interest to this subcommittee. AAAHC reviews the marketing and advertising materials distributed by a surveyed facility to ensure that those materials are not deceptive or misleading. AAAHC's surveyors directly review the physician's credentials, training, and experience against the surgical procedures authorized to be performed in that facility to ensure that the surgeon is qualified. An accredited organization must either have a written transfer agreement with a nearby hospital or must permit elective surgery only by practitioners who have admitting privileges at a nearby hospital.

In solo physician organizations, an independent outside physician must be involved in quality assurance activities. We are proud of the fact that AAAHC's accreditation standards exceed Medicare certification requirements and State licensure requirements for ASC's.

It is important that I emphasize to the subcommittee this morning that AAAHC's accreditation process ensures that only the highest quality facilities attain accreditation. For this reason, AAAHC is not in a position to determine the need for additional Federal regulation to address substandard care in office-based cosmetic surgical practices. Facilities which apply for voluntary accreditation are those dedicated to quality. Also, applicants generally spend significant time and resources preparing for the accreditation survey. Thus, AAAHC does not have an extensive information base relating to substandard facilities.

Should accreditation be mandatory? Historically, AAAHC accreditation has always been a carrot rather than a stick. The voluntary nature of AAAHC's accreditation program has been fundamental to its philosophy since its inception. We believe that a voluntary, pluralistic, peer-based approach is effective in improving health care services. This approach fosters innovation and provides motivation. Our goal has not been to sanction or regulate, but rather to assist and to educate. Moreover, AAAHC's accreditation program works because of the commitment and dedication of its surveyors, all of whom are practicing physicians, nurses, or administrators. All surveyors are volunteers willing to dedicate their time and efforts to assisting others to assure high quality care. We do not believe that the quality of our surveyors could be duplicated in any mandatory system.

Finally, AAAHC's standards are higher than the standards of most regulatory systems. While most regulatory systems seek to ensure compliance with minimal standards of care, AAAHC seeks to ensure compliance with the highest quality standards. However, if Congress concludes that minimum Federal standards are necessary, the law we feel should explicitly provide for deemed status for AAAHC-accredited facilities. AAAHC's standards meet or exceed Medicare certification requirements for ASC's. By failing to implement a deemed status mechanism, the Federal Government has failed to provide the proper incentive for facilities to become accredited. Thus, if Federal legislation is drafted to establish minimal standards for cosmetic office-based surgical practices, such legislation should explicitly provide deemed status for AAAHC-accredited office-based facilities.

Any new law should also provide deemed status for AAAHC-accredited ASC's for Medicare certification purposes. These deemed status provisions would provide incentives for both office-based surgical practices and ASC's to meet AAAHC's high quality standards.

Finally, if the subcommittee determines that Federal minimal standards are necessary, AAAHC would be pleased to work with the subcommittee or the appropriate administrative agency to ensure that such standards are reasonable and appropriate. Over the past 10 years AAAHC has accumulated a wealth of experience concerning what constitutes quality in outpatient facilities, and we would be most pleased to share that experience with the subcommittee.

Again, we appreciate the opportunity to testify with regard to these most important issues, and Mr. Moen and I would be pleased to respond to any questions that you may have at this time or to provide any further information that may be useful to the subcommittee. Thank you.

Mr. ENGEL. Thank you.

[Dr. Battaglia's statement, with attachments, may be found in the appendix.]

Mr. ENGEL. Chairman Wyden has asked me to sit in for him for a while. He had another meeting to go to.

I would like to ask you some questions regarding surgery performed in an outpatient setting rather than in a hospital. Why should the American medical consumer, and those of us who are in Government, and the medical community itself be concerned about the growing trend of surgery being performed outside the traditional hospital setting? Or should we not be concerned?

Dr. BATTAGLIA. Well, I think the trend is a favorable one, certainly, for the reasons that I have cited in the oral statement. The trend is a good one in that it is more convenient, it reduces cost, it provides convenience—all of the reasons that the subcommittee is already familiar with. So, in a sense, I would say that the consumer, in general, does not need to be concerned with the movement of procedures that used to be performed in hospital settings to the outpatient setting. The concern of the subcommittee, as I understand it, is with ensuring quality in the outpatient setting.

Mr. ENGEL. Well, many people say when you speak of quality that patients have more quality care in a hospital. The types of quality care that we are all looking for exist in a hospital but not in a doctor's office. You disagree with that, obviously.

Dr. BATTAGLIA. I disagree with that partially, that is correct.

Mr. ENGEL. Could you elaborate?

Dr. BATTAGLIA. Again, I would say that organizations that have sought accreditation through our agency or through the AAAAPSF or through JCAHO have demonstrated their commitments to quality, which is the equivalent, and in my humble opinion in many ways superior to, care that can be rendered for that given procedure in a hospital setting.

Mr. MOEN. I think you have to look historically, Mr. Chairman, at the fact that if you go back early in the history of medicine in this country almost all care was provided in doctors' offices. The evolution of hospitals, the teaching hospitals, and the financial support through insurance and other third-party mechanisms really fostered the creation of the modern hospital as we know it now. Most procedures then were done in a hospital, because insurance paid for it.

With growing technological developments, both in anesthesia and surgical techniques, many surgeons find that many procedures that were once thought to be performed only in a hospital are, in fact, better performed in an ambulatory surgery center, and a lot of procedures that were once done only in an ASC are now moving into an office surgical setting.

You can look at this in a variety of specialties, not just in cosmetic surgery. Look at the many procedures in ophthalmology and at orthopedics, for example, the development of arthroscopy and others; these are all being done on an outpatient basis.

Mr. ENGEL. I would agree with you, if the outpatient facilities are accredited. But I think it sends, personally, a terrible message, the fact that 9 out of every 10 outpatient surgical facilities in this country aren't inspected by any organization. The public really has no guarantee that the one they are going to is up to standard, which bothers me. At least, in a hospital you have the feeling that the standards you know are pretty good. You wouldn't disagree with that, would you?

Dr. **Battaglia.** No, sir; I would not disagree with your opinion. Our position, however, is that decision is a policy decision to be decided by representatives of the public, of whom Congress is certainly a prime example.

Mr. **Engel.** Are there not requirements in hospital-based surgery to ensure that the operating room is fully equipped with life-support equipment to routinely protect the patient?

Dr. **Battaglia.** In accredited hospitals. In licensed hospitals; yes, sir.

Mr. **Engel.** But that would not be the case in most of the outpatient facilities?

Dr. **Battaglia.** It is also the case with accredited ambulatory surgery facilities and licensed ambulatory surgery facilities; yes, sir.

Mr. **Engel.** Right, but those are the two key words—accredited and licensed—of which 10 percent or less are.

What type of Federal legislation, accrediting legislation would your organization be willing to support to remedy the overriding concerns that the medical community and others have expressed?

Mr. **Moen.** Well, there are, I think, several pieces to this. First of all, look at the Omnibus Reconciliation Act of 1980. There was a provision in that law that provided for reimbursement through the Medicare system for office surgical practices and for payment of a facility fee in that program. That provision in that law has never been implemented. You have had others testify, as well, that they believe that provision should be implemented.

When the regulations were developed for ASC's, AAAHC provided the basic information for the standards, which were then the minimal standards that were incorporated into the Federal Medicare system. As we have already testified, that if you proceed with this development of mandatory program, I think you have to make a distinction between what we would see as accreditation, which are essentially optimal standards or optimally achievable standards, and those standards that might be minimal standards, and we would be pleased to work with the subcommittee staff, and with yourself, and others on the specifics of that. We have already indicated in the prepared testimony what some of those standards are that relate to rights of patients, facility standards, governance, administration, quality assurance, quality of care, and others.

Mr. **Engel.** Why should we settle for less than what your accreditation standards are? I mean, we don't want the minimum standards. I think we had asked the question of the previous panel, Mr. Wyden did, about minimum standards, and one of the panelists said he didn't like that word. I don't either.

Mr. **Moen.** Well, I think you have to look at what people perceive or the public perceives as the connotations for those terms, and there has historically been a distinction between certification and licensure. Licensure is usually a permission to operate and has what some of us might call adequate or minimal standards versus the optimal standards.

It is not easy to become accredited, and the time, and energy, and investment that it takes to do that is significant. We, as an organization, do not have the kind of data that has been alluded to by other people that have testified before you regarding this, and that is why our position is perhaps a bit more conservative.

Mr. **Engel**. What else does your board believe that Federal, State, and local governments must do to protect the public from the totally unregulated outpatient surgical setting that exists today?

Mr. **Moen**. Well, we believe strongly that the mechanisms already are in place for some aspects of this issue for the Federal Government, and thereby the States, to support. If deemed status, for example, were in place, we believe that there would be a strong movement in a very short period of time for people to seek and achieve accreditation. We have data to indicate that the application of the existing Medicare standards on a State-by-State basis is very inconsistent. We have found instances in which Medicare-certified ASC's have not been able to be accredited because they don't meet the requirements in quality assurance and quality of care. So, we believe that the support for deemed status would be a very powerful first step in this process, while you look at the other issues that would be involved in a mandatory program.

Mr. **Engel**. In the written testimony, you mentioned that outpatient surgery affords the surgeon the opportunity to exercise greater control over the surgical environment while minimizing the cost to the patient. In some of the answers to my questions, you essentially said the same thing. My concern is that, again, this is a double-edged sword, especially in cosmetic surgery. It is cheaper surgery, but it is performed without any of the guarantees offered by the hospital, or a fully accredited facility, by your organization, or an organization similar to yours. Again, that really is my great concern with trading one thing, but we may be creating something that is even worse than what we are gaining.

Mr. **Moen**. I think if you look at our accredited facilities, whether they be plastic, or cosmetic, or ophthalmology, or whatever, you will see that they meet or exceed not only the Medicare requirements, but many of them are very similar to hospital settings. They have all of the appropriate safeguards, and we don't find those ASC's to be any more expensive than other places. In fact, they are considerably cheaper than the hospital environment. But studies done by the Federated Ambulatory Surgery Association, for example, indicate that infection rates are lower in those kinds of settings than they are in other settings such as hospitals.

Mr. **Engel**. You mentioned—again, the advantages of technology in anesthesia and surgical techniques—that over 50 percent of all surgical procedures could be safely and cost effectively performed on an outpatient basis. Again, this assumes that the procedures are being performed in facilities that meet your standards. Am I correct?

Mr. **Moen**. That is correct.

Dr. **Battaglia**. Yes, sir.

Mr. **Engel**. Then we get back to the fact that 90 percent are not inspected or accredited, so it is really almost a catch 22.

Mr. **Moen**. We would agree that there are significant numbers of places that do not meet our standards and have chosen not to, and we have no way as a voluntary organization, of seeking those out for evaluation. That is obviously why you are holding these hearings and dealing with that issue as a public policy issue.

Mr. **Engel**. Doesn't that scare you? It scares the hell out of me. Your standards are very comprehensive and address, I think, 21 areas of great concern to your organization when you evaluate facilities. We obviously have a need for such comprehensive standards to protect the patient. But it scares me to death. Doesn't it scare you to death, knowing that almost the entire universe of outpatient surgical care in this country doesn't even apply for accreditation?

Mr. **Moen**. We would much prefer to see them all become accredited. There is no doubt about that. That is our stated purpose. We are also well aware, as Mr. Stygar alluded to in earlier testimony, that this is an issue that doesn't address just cosmetic surgery. But if you look at what could be classified as cosmetic surgery, there are a variety of surgical techniques and procedures, including those that have not been mentioned here, that would really have to be addressed if you are going to create new legislation. That is why we are urging you to take a very careful look at the Omnibus Reconciliation Act that was passed in 1980. This committee and others in Congress could certainly help move along deemed status for the existing ASC Program. That would give us the kind of data that I think you and HCFA are looking for in comparing a number of these facilities. That option exists in the law; to apply standards such as ours to the office surgical environment. Deemed status would give you information that is currently not available at HCFA.

Mr. **Engel**. Very well. I thank both of you very much for your testimony and for your answers to the questions. I know that I have found it very enlightening, and I know Mr. Wyden does as well.

Dr. **Battaglia**. Thank you very much.

Mr. **Engel**. We will be looking forward to working with you in the next couple of months to develop such legislation. Obviously, that is the purpose of these hearings, and we have had several of them now. Thank you very much.

I have noticed that the hour is 12:30, and I think what I am going to do, before we get to the next panelists, is to have a short break for lunch. It is 12:30 now. Why don't we come back at about 1:15.

Thank you very much.

[Whereupon, at 12:30 p.m., the subcommittee was recessed, to reconvene at 1:15 p.m., the same day.]

Chairman **Wyden**. The subcommittee will come to order.

Again, the chair wants to apologize to all our witnesses for the incredibly harried nature of today's hearing. We didn't anticipate this. Fortunately, the Chair is very lucky to have our capable colleague from New York, Mr. Engel, who is helping us to keep the ship afloat.

Dr. Battaglia, if you would be willing, I would like to bring you back for a moment. Then we are going to try to move for just a few minutes while the Chair can remain. Then we are going to bring our next panel, with Dr. Tobin.

Dr. Battaglia, I thank you for your patience. Under normal circumstances, you had every right to believe you would be excused.

Dr. **Battaglia**. My pleasure, and I apologize for the fact that Mr. Moen has caught a flight back because this is his 25th wedding anniversary.

Chairman **Wyden**. You have been gracious, and we appreciate it.

Is it your view that there is a significant problem out there overall that the subcommittee is seeking to address, with respect to outpatient cosmetic surgery facilities?

Dr. **Battaglia**. I believe that the subcommittee is correct in investigating the problem. I think that there is a problem. I, as an anesthesiologist, would hesitate to quantify the problem by saying it is a significant problem. I am really not qualified to make that statement or to answer the specific question that you have addressed.

Chairman **Wyden**. Since we agree that we have a problem, do you think it is a problem that can be handled on a voluntary basis?

Dr. **Battaglia**. Given the appropriate incentives, certainly our position would be that we would like to see the problem approached in that direction as a first step, and to see if that approach would resolve the perceived problem. If it did not, then I think we would be more enthusiastic in our support of some sort of mandatory regulation.

Chairman **Wyden**. If it could be handled by voluntary purposes or voluntary approaches, why wouldn't it have been handled already?

Dr. **Battaglia**. Mainly because we feel that the incentive has not been provided to individual organizations to seek accreditation.

Chairman **Wyden**. What kind of incentives are you talking about?

Dr. **Battaglia**. Well, again we refer to HCFA's delay in implementation of deemed status for those organizations which have been recognized as being quality organizations as indicated by their being accredited by one of the recognized accrediting agencies.

Chairman **Wyden**. But many of the facilities aren't doing reimbursable procedures, so they wouldn't be covered under HCFA. See, I start with your view that there is no reason to legislate if you can handle it voluntarily. I don't see how in the world you can handle this voluntarily. I think if it could be handled voluntarily, good people like you and other witnesses would handle it voluntarily.

You have just brought up HCFA. Frankly, I think the concept of deeming, so that you use people with good qualifications and build that into your statutory approach, much along the lines we tried to recognize in what had been done with CLIA, makes a good deal of sense. But what are you going to do about the people who aren't qualified or would not be swept under a HCFA approach? What do we do with them? Don't we need Federal legislation?

Dr. **Battaglia**. As I said in our position paper, that is a policy decision that we don't have the data to comment on, really.

Chairman **Wyden**. What incentive exists for somebody who doesn't get reimbursed? There isn't any, is there?

Dr. BATTAGLIA. I would have to agree with you that right now there is not. That is correct. Other than the vast majority of individuals with single specialty office practices who are conscientious, dedicated, competent practitioners. These individuals, given accreditation, or unaccreditation, or in the absence of accreditation, continue to provide quality care. You are concerned with those individuals on the periphery of the system who——

Chairman WYDEN. Look at some of those out there on the periphery.

Dr. BATTAGLIA. Yes.

Chairman WYDEN. Let's be quite clear that it is not just two or three that are out on the periphery, but virtually every time you open a magazine in a major metropolitan area, you see advertisements that represent people who are pretty close to the periphery.

Dr. BATTAGLIA. I don't wish to appear argumentative, and I emphasize the fact that as an anesthesiologist this is not my area of expertise, but aren't we talking here about advertising as a separate issue, perhaps, from quality medical practice?

Chairman WYDEN. Oh, no; I think that we have come up with a couple of things. That good advertising, advertising that lets people make informed choices, is right at the heart of trying to get good quality care. Because if you are going to make good choices and try to get to a practitioner who gives you good quality care, you have to get after the information. So, I think that the Federal Government has a strong obligation under the FTC statute to deal with deceptive and false advertising. It is my view that good information that is made available through advertising and the like is directly related to a citizen's ability to get good quality care. Because they can't make an informed choice, they can't choose between Practitioner A and Practitioner B if all they are getting is a bunch of overblown, excited rhetoric. So, that is right at the heart of what this subcommittee is trying to do.

Dr. BATTAGLIA. Mr. Chairman, as an individual and on behalf of the association, I could not agree with the statement that you have made more. I think that is absolutely accurate.

Chairman WYDEN. You have been patient and very helpful. Let me leave the record open on the point specifically, and do talk to your colleagues and Mr. Moen about how we would deal with such a problem voluntarily, because I am of the view that it cannot be dealt voluntarily. A lot of the people we are most concerned about—the scofflaws, the people who are doing a lot of the junky advertising and operating in facilities that you would never permit your people to use—couldn't care less about what somebody in the U.S. Congress is doing in a bunch of hearings. They are not going to come forward voluntarily. The HCFA rule, while a useful tool, isn't going to pick them up. I don't know how we are going to get them voluntarily.

Now, in saying that, and we want to leave the record open, I want you to understand that I have considerable sympathy for the notion of using standards that are already in place from substantial accrediting organizations and build on those. That is exactly what was done with the CLIA bill. We didn't run out there and say, "Well, the Federal Government is now going to unravel everything that is being done in clinical lab legislation." Quite the opposite. We said, "We are going to build on their good work, have, in effect, these Federal minimum standards so we can pick up people who will not otherwise come forward voluntarily." That is my interest here. Not in wiping out the existing programs, but figuring out how we can pull those programs into what amounts to a seamless web so that everybody is part of a system with minimum standards. That is the Chair's interest.

Dr. BATTAGLIA. Again, we appreciate the opportunity, and we reaffirm our intent to work with your committee, and, if we can figure out between us some way to encourage voluntary compliance so that your objectives are met, we would love to do that.

Chairman WYDEN. I will ask you one other. Do you all have any special problems with looking to the CLIA model, as a model trying to address this issue?

Dr. BATTAGLIA. Again, I don't think we have any special problems. But our legal counsel, I think, knows more about CLIA than I personally do.

Chairman WYDEN. I understand. You have been very helpful. We will be in touch in the days ahead.

Dr. BATTAGLIA. Thank you, and congratulations to you on your quest. We appreciate it.

Chairman WYDEN. Thanks very much.

Dr. BATTAGLIA. You bet.

Chairman WYDEN. Our next panel, let us swear them in. I am going to turn it over to my colleague then.

Dr. Howard Tobin, board member of the American Board of Cosmetic Surgery.

Doctor, we welcome you. It is a practice of the subcommittee to swear all our witnesses. You have no objection to being sworn?

Dr. TOBIN. No, sir.

[Witness sworn.]

Chairman WYDEN. Consider yourself sworn.

Mr. ENGEL [presiding]. Doctor, we will take your written testimony and put it in full in the official record, so if you could take 5 minutes to, essentially, summarize the main points and elaborate on them.

Dr. TOBIN. I will try my best, Mr. Engel.

Mr. ENGEL. Thank you.

TESTIMONY OF HOWARD A. TOBIN, M.D., F.A.C.S., BOARD MEMBER, AMERICAN BOARD OF COSMETIC SURGERY, AND DIRECTOR, AAAHC

Dr. TOBIN. The written testimony that you have is fairly extensive. This summary is already summarized, and I will try to summarize it as best I can.

Mr. ENGEL. We will put the whole statement in the record, so that it will be as if you read the whole thing.

Dr. TOBIN. I would like to introduce my remarks by first complimenting you in your efforts, you and chairman Wyden, and I also want to express my admiration for the investigators who have been involved with this project since the beginning. These two individuals, D. Ann Murphy and Frank Papineau, are dedicated people who have shown a real commitment to doing work that is in the public interest, and my hat is off to them. I think they deserve that recognition.

I want to introduce my remarks by emphasizing that the vast majority of doctors engaged in cosmetic surgery, whether as a sole specialty or as a part of their practice in another field, are doing a responsible and credible job. To bring the discussion of office-based surgery into perspective, we must understand that the move to outpatient health care is not unique to cosmetic surgery.

It is an oversimplification to try to decide whether cosmetic surgery should be done in a hospital, a doctor's office, or any other specific type of facility. Furthermore, the majority of surgeons engaging in cosmetic surgery do so as a part of some other specialty that occupies a significant part of their practice. Practice limited to cosmetic surgery is the exception rather than the rule.

As a director of AAAHC, I serve as the representative of the American Academy of Facial Plastic and Reconstructive Surgery, and this academy works to educate and encourage its members to provide safe and effective outpatient surgical care in many ways. One very important way is through its affiliation with AAAHC, but that is not the only way by which a surgeon can develop a safe and effective office-based operating environment.

As we have heard before, accreditation is not the minimum standard for outpatient health care; it is the highest. The road to accreditation is not easy. It takes many months for a facility to prepare for an accreditation survey. But there is a far greater reason why many facilities do not seek accreditation. At the present time, incentives for accreditation are woefully lacking, and at the conclusion of my remarks I will have some suggestions which I feel can help to increase the incentives.

In addition to my responsibilities in the American Academy of Facial Plastic and Reconstructive Surgery, I have also served as chairman of the Ambulatory Surgical Committee of the American Academy of Cosmetic Surgery. Since its inception, this organization has demonstrated a strong commitment toward educating its members in safe outpatient surgical care. In fact, the academy has applied for a position as a sponsoring member of the Accreditation Association for Ambulatory Health Care.

The American Board of Cosmetic Surgery has also made a firm commitment to accreditation by considering it a requirement for newly certified members who do their work in office-based surgical units. It is the American Board of Cosmetic Surgery's intention to require AAAHC. This represents the strongest commitment to accreditation that has ever been expressed by a certifying organization, and I applaud this move which I feel will serve as a very important precedent.

Today, you have heard testimony by representatives of an accrediting organization that represents the members of the American Society of Plastic and Reconstructive Surgery. It is not my intention in any way to criticize the goals or accomplishments of that body, but I do want to point out one very major difference between this organization and AAAHC.

AAAHC was formed to provide peer-based review for a variety of ambulatory health care facilities based on the premise that generic standards can be developed which apply to a multitude of practice situations. A multidisciplinary accreditation organization is bound to be superior to one that is controlled by a single specialty or organization.

You have asked me to comment upon the significance of doctors performing procedures in outpatient facilities for which they do not have hospital privileges. Hospital politics have long been recognized to be grossly unfair in many circumstances. Nowhere is this better exemplified than in the arena of granting surgical privileges.

Being denied hospital privileges in a given procedure does not mean that the doctor is unqualified to carry out the operation. It may simply be a reflection of the fact that the credentials committee at the local hospital was controlled by vested interests that were attempting to stifle competition. Much of this unfair limiting of surgical privileges has been fostered by surgeons who insist that only members of their specialty have adequate training to carry out cosmetic surgery.

Now AAAHC is well aware of this credentialing problem, and for that reason AAAHC accreditation requires that independent credentialing be carried out. That is to say, that a surgeon should not simply be granted or denied privileges based on privileges that he holds in a hospital.

In cosmetic surgery, learning usually occurs after the formal training period. In his presidential address to the American Society for Aesthetic Plastic Surgery, Dr. Thomas Baker, an eminent plastic and reconstructive surgeon, reminded his colleagues that the training received by a plastic surgery resident is often woefully lacking. Dr. Baker stated that, "In my particular training program, little or no aesthetic surgery was done, especially by the residents."

The final issue that you have asked me to address is that of advertising. Consumers deserve a choice, and advertising is one means by which they can become educated about the choices open to them. To deny advertising simply allows the entrenched incumbent surgeon to prevent competition, and this is not to the advantage of the consumer.

This committee has spent many hours investigating the field of cosmetic surgery. I know that one of your goals is to help to encourage accreditation. I certainly share your enthusiasm in this area. However, I feel strongly that accreditation can function best in a deregulated environment which is likely to ultimately benefit the consumer.

Perhaps, I can offer a few suggestions about what the Federal Government can do to help us become more successful in encouraging voluntary accreditation. For several years AAAHC has been attempting to work with HCFA to establish a process of dual certification called deemed status. We have discussed this already, and I think that the Government should consider ways to help to implement this program.

Another area in which I feel that this committee can be of value is in the area of public education. I feel that it would be very appropriate for the Government to use its considerable resources to educate consumers fairly about the benefits of accreditation and the choices involved. I am convinced that AAAHC accreditation is the best available means by which a facility can demonstrate to its patients that it is providing high quality care. Recognition of this by the Government would encourage many more of my colleagues to achieve accreditation.

As I conclude my presentation, I would hope that upon careful reflection of the evidence that this committee has studied it will use its considerable influence to discourage those members of the profession who would stifle free competition in the field of medicine. Most doctors are dedicated to providing their patients with the best possible care. We realize that we are far from perfect, but day after day we try to learn to improve our skills and to treat our patients with care, honesty, and compassion.

I am deeply saddened by the bitter fighting that has occurred in an area of medicine that I feel to be extremely important and to which I have dedicated my life. Cosmetic surgery is a wonderful field. There is plenty of work for all of us who are willing to spend the time and effort required to learn this type of care. There are many avenues that can lead toward a successful cosmetic surgery practice. All of us can learn from our colleagues with different backgrounds. Perhaps, you who have had the opportunity to look at all sides of this issue can help to bring us together in our common goals of serving the public good.

Thank you for your consideration, and I will be glad to answer any questions.

Mr. ENGEL. Thank you, Dr. Tobin.

[Dr. Tobin's statement, with attachments, may be found in the appendix.]

Mr. ENGEL. I have a few questions for you. Unfortunately, I have to run to take a vote now. This has been a very interesting day, to say the least. So, I am going to have to call another break in the hearing. I am wondering if you can stay around, and I have a few questions for you.

Dr. TOBIN. Yes, sir.

Mr. ENGEL. I would approximate the break to be about a half hour because there are several votes.

Thank you very much.

[Recess.]

Mr. ENGEL. We will reconvene the hearing.

I would like to call up, for the American Board of Medical Specialties, Peyton E. Weary, president-elect of ABMS, and Donald G. Langsley, M.D., executive vice president of ABMS.

Gentlemen, do you have any objection to being sworn?

Dr. WEARY. Not at all.

Dr. LANGSLEY. No.

[Witnesses sworn.]

TESTIMONY OF PEYTON E. WEARY, M.D., PROFESSOR AND CHAIRMAN OF DERMATOLOGY, UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE, AND PRESIDENT-ELECT, AMERICAN BOARD OF MEDICAL SPECIALTIES [ABMS], ACCOMPANIED BY DONALD G. LANGSLEY, M.D., EXECUTIVE VICE PRESIDENT, ABMS

Dr. WEARY. Mr. Chairman, I am going to turn on my timer so I will not exceed my allotted time.

Mr. **Engel**. They have assured me there will be no votes coming up in the next few minutes, so I trust that we will finish. But don't hold me to it.

Dr. **Weary**. Mr. Chairman, I am Dr. Peyton Weary, professor and chairman of the Department of Dermatology at the University of Virginia School of Medicine, and president-elect of the American Board of Medical Specialties, the ABMS. With your permission, I would like to use the abbreviation ABMS in my references to the American Board of Medical Specialties in my continuing remarks.

With me today is Dr. Donald Langsley, executive vice president of the ABMS.

We are presenting this testimony on behalf of the ABMS, which is the umbrella organization of the 23 medical specialty certifying boards which have been approved and recognized by the Liaison Committee for Specialty Boards, the ABMS, and the American Medical Association. These are the medical specialty certifying boards which are generally recognized throughout the American Health Care System. It is the responsibility of these boards to provide assurance to the public that a certified medical specialist is a physician who has successfully completed an approved educational program of 3 to 7 or more years, and who has passed an evaluation process which includes an examination designed to assess the knowledge as well as the skills and experience requisite to provision of quality patient care in that specialty.

Certifying boards have been in existence since 1917, when the American Board of Ophthalmology was organized. By 1933, there were actually four boards, and they joined at that time with the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, the Federation of State Medical Boards, and the National Board of Medical Examiners to establish the ABMS. The purpose of the ABMS was to improve medical care through the setting of professional standards and surveillance of medical qualifications.

In 1934, the ABMS and the AMA joined forces to develop a system for approving and recognizing new boards. At that time they organized the Liaison Committee for Specialty Boards, the LCSB. The LCSB functions under a set of essentials for the approval of examining boards in medical specialties which set forth the criteria for and the process for approval of new specialty boards. The criteria for approval are outlined in our written testimony.

In addition, you should be aware of the fact that the ABMS has supported the concept of recertification, and, in fact, most boards have adopted the use of time-limited certificates so that in order to maintain certification a physician must be recertified every 7 to 10 years.

We have outlined also in our written testimony other mechanisms which the medical profession has put in place to assure the public safety and the need for professional self-regulation and quality control. Unhappily, however, the statement that a physician is board certified is really not enough. There are at least 105 self-designated boards of which we know, and there is no system for guaranteeing that such boards meet the same high standards required for ABMS and AMA approval and recognition. In our country, anyone can organize a board and name it the American Board of whatever. Those who organize such boards set their own standards. They may waive any required education and they may waive any examination process for that matter. Some of these self-designated boards have very high standards and require residency training plus an examination in a fashion similar to that of the ABMS member boards. We have encouraged them to consider application to the LCSB for recognition and approval.

To the average citizen, the advertisement of being board certified carries with it an expected level of qualifications and competence which may not really coincide with reality. If a physician is a member of the medical staff of a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations and has privileges to practice in that hospital, it generally indicates that the qualifications of the physician to claim board certification have been reviewed at least. However, many physicians confine their practice to their private offices.

We have tried to increase the public awareness of this situation, but you must understand that this is a significant challenge to educate all of America about this complex process. We have become increasingly concerned about advertising, especially in the Yellow Pages. According to a study done by Statistical Research of Westfield, NJ, 35.4 percent of adults—23.3 million per month—use the Yellow Pages when obtaining the services of a physician. Without passing judgment on the tastelessness of some of the ad content, we do express concern about the numbers of ads which simply state "board certified" or "board certified specialist."

A study by Reed & Ratson, published in the New England Journal of Medicine in 1987, found that 12 percent of specialists listed in the Yellow Pages in Hartford, CT, were not board certified. A national survey done at that time of 1,504 individuals found that 62 percent thought that advertising in telephone books or newspapers would help people choose a doctor.

We would hope that some mechanism can be devised to better inform the public about the meaning of certification and the quality controls which should be inherent in such a designation. As examples of some activities at a State level which are being implemented right now or are in the process, I would like to summarize the following.

States which have adopted the rule that physicians who claim to be board certified must be certified by a member board of an organization satisfactory to the State Medical Board, and to date, that is ABMS approved, are Florida and Oklahoma. States which have adopted the rule that physicians who claim to be board certified must state the name of the board and must be currently certified, are the District of Columbia, Maryland, Mississippi, New Jersey, Oregon, and Texas. Then there are a number of States which are giving serious consideration to the rule described above for the last six States which I listed, and these are Alaska, Alabama, Georgia, Iowa, Maine, Nevada, North Carolina, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, and West Virginia.

We very much appreciate the opportunity you have presented us to give this testimony, and we'll be glad to answer any questions you may have.

Mr. **Engel**. Thank you, Doctor. I appreciate you summarizing your testimony. It will be entered into the record.

Dr. Langsley, do you have a statement?

Dr. **Langsley**. No; I am pleased to join Dr. Weary in trying to answer any questions that you may have, Mr. Chairman, but I did not have an additional statement.

[Dr. Weary and Dr. Langsley's joint statement, with attachments, may be found in the appendix.]

Mr. **Engel**. Dr. Weary, considering the level of technology in medicine today, do you think that the medical community should continue to take the position that a doctor with a medical degree and a State license has the right to decide by himself what surgical procedures he will perform and where he is going to perform them?

Dr. **Weary**. I think that it would be very appropriate for us to study this and find out exactly whether there is a problem and what the problem is. I don't think we have enough information to make an informed decision about that at this time.

Mr. **Engel**. Well, isn't it a fact that board certification, as we know it, developed as one of the medical community's attempts to rid itself of some medical quackeries from its ranks in the early 1900's?

Dr. **Weary**. Yes; very much so.

Mr. **Engel**. Is that how it happened, and wasn't another step by the medical community the elimination of false and deceptive advertising by its members?

Dr. **Weary**. Well, I think false and deceptive advertising definitely should be eliminated.

Mr. **Engel**. Do you believe that the FTC's attack on medicine in the 1970's reduced medical cost to consumers and improved the quality of medical care in the country?

Dr. **Weary**. I am not informed enough about that to make a judgment on that. Perhaps Dr. Langsley might comment.

Dr. **Langsley**. Mr. Chairman, I am afraid that since the 1970's medical costs have done nothing but go up. If the FTC is claiming that they have managed to reduce medical care costs, I think we ought to ask them for the evidence, if that is the situation.

Mr. **Engel**. Well, let me follow that a little bit. Do you believe that any actions by the FTC or other governmental agencies over the last decade have had any adverse effect on the 23 ABMS medical specialty certifying boards or the public's ability to identify a qualified specialty doctor through the reams of medical advertising out there?

Dr. **Langsley**. I would think, Mr. Chairman, and I am sure that Dr. Weary agrees with this, that the whole purpose of the FTC's efforts at encouraging advertising has resulted in a fair amount of confusion in the mind of the public about what a doctor's qualifications really are. If we encourage doctors who are not certified by one of the recognized and approved boards to be able to say that either they are just board certified or that they are board certified by one of the self-designated boards, it is hard enough for a professional and a medical group to figure out what all that means. To then turn to the public and expect them to understand is, I think, an overwhelming task.

Dr. **Weary**. We have very much been concerned about this for a long time, Mr. Chairman, and we have developed a brochure, which you have received a copy of, to try to inform the public better of the significance of board certification and what really should be the qualifications and requirements for board certification because of a great concern about the self-designated boards and the use of the term "board certified" or "specialist" without any identification as to what this board certification meant, what board certified the individual. So, we have been concerned about it, very much so, and I suspect that the substantial increase in advertising that has taken place over the past several decades has greatly magnified the problem.

Mr. **Engel**. Do you feel that the qualifications of the self-designated boards differ substantially from the 23-member boards of the ABMS?

Dr. **Weary**. I think that there is a tremendous variation in the requirements of some of the self-designated boards. Some of them do have substantial requirements which are comparable to those of ABMS certifying boards. Others, however, have substantially less requirements, and I think that we have tried to get information about what the requirements of many of these boards are, and it is very difficult for us to obtain that sort of information. So, I think that one can say that there is a marked variation.

Mr. **Engel**. Would you say that the ABMS seal of quality medicine in this country has become obsolete because the self-designated boards have equal weight in advertising to the public?

Dr. **Weary**. No; well, I think that the public is certainly aware of the importance of the term "certified." I think that where the public is, is that the public has not been well enough informed that there is this marked variation that we find, and I think what we have to do is a better job of informing the public about the variation and the differences in the term "board certified."

Mr. **Engel**. Well, what actions, therefore, have ABMS members taken to educate the public, and what further actions do you think need to be taken by the medical community and the Government to educate the public? I am wondering if Dr. Langsley could also comment on that?

Dr. **Langsley**. I would be glad to try, Mr. Chairman. You asked this question, introduced by the term or by the question as to whether the ABMS certification has become obsolete. I would like to believe that it has not become obsolete. But I would also believe that because of the existence of these other boards, then advertising about board certification has made it more difficult for the public.

What we have tried to do is a series of things, all of them very challenging. We have tried to publish booklets, but even the 50,000 booklets, an example of which you have before you, reaches only a small proportion, and I am not sure how well and widely it is read, except by already sophisticated people. We are embarked on trying to encourage the Yellow Pages directories of this country to devote a special section to identifying which specialists are certified by an ABMS board. We hope that will have some helpful effect.

On the other hand, we also are encouraged by the fact that some States have taken a position that if one is going to claim board certification, that at a minimum one has to identify the board and the fact that the certification is current.

I personally—this is not an ABMS position—would like to additionally see the option there for a physician who is saying I am board certified to be able to state not only the board but whether the board is one of the ABMS members. I understand what the concerns of the subcommittee are about this, concern about the effect of this advertising on the public's ability to get quality medical care and to make a judgment itself, particularly in the area of physicians who are carrying on procedures outside of a hospital.

You also asked earlier what controls are there over what a doctor can do. Well, if it is done in a hospital, there is a hospital medical staff. If it is practice within the private office of a doctor that, unfortunately, is uncontrolled, and that, of course, is one of the themes that we are hearing.

Mr. **Engel**. You have been here for a number of hours now, and you have heard what some of the other panelists have said, and I'd like to ask you the same question that I asked them. What fixes should the Government consider?

Dr. **Weary**. Well, I think that one of the things that we need help with is this very business of informing the public. The Federal Government has a tremendous clout and ability to get messages before the public. For instance, I received yesterday in the mail a little brochure from the Food and Drug Administration that was entitled "Advice to the Patient by a Doctor," and what it did was to inform the patient about the appropriate use of over-the-counter drugs. It was written by Frank Young, and I am sure he had a lot of assistance from a number of people. But it was mailed out to I don't know how many thousands of people, probably a substantial segment of the population.

Now, with that sort of clout, it would be possible for the Federal Government if they wish to mail out some sort of mailing to the public which would try to put the whole process of board certification into some reasonable perspective so that they would have some information at least about the fact that the term "board certified" without any further additional qualification is not necessarily a significant credential. That is the sort of thing that I think we could use help with, and I see no reason why, if Frank Young can send this out from the Food and Drug Administration, that some other agency of Government could not send out something comparable to this. I think it would well serve the public if this were done.

Dr. **Langsley**. If I may, Mr. Chairman, I might also add that even though the ABMS has not taken a position on this issue of having some kind of regulation, we did do with the help of one of our colleagues a survey of all the 54 State jurisdictions. We are not eager to see the Federal Government to jump into an area that is a new area or a novel area, but we recognize that it is also very difficult to establish a standard that will be adopted uniformly by all 54 licensing jurisdictions. We do understand your concern about the ability to simply state "board certified" without qualifying what the meaning of that statement is.

Mr. Engel. I am wondering if you could comment on the resolution which was approved by the AMA House of Delegates just last week on June 20. I would like to just read part of it.

It says,

> Whereas, the FTC has effectively barred the American Medical Association from establishing meaningful standards for medical advertising that is truthful, informative, and not deceptive.

It continues,

> Whereas, State medical licensure authorities are similarly restricted, and whereas the American public has been endangered by deceptive and untruthful medical advertising promising risk-free, pain-free outpatient treatment and surgery without loss of time from work and results far beyond reasonable expectations; whereas, much of this treatment and surgery, particularly elective cosmetic procedures, is performed by physicians without specialized training in the procedures they perform and with inadequate facilities; and, whereas, the FTC, while effectively barring private organizations from establishing and enforcing standards, it does not exercise its authority to adopt and enforce reasonable standards in medical advertising; therefore, be it resolved, that the AMA requests that the Federal Trade Commission conduct hearings where interested parties may be heard for the purpose of establishing FTC standards governing truthful, nondeceptive, and nonmisleading advertising.

Dr. Weary. I will comment to the effect that I think that is a very reasonable request.

Dr. Langsley. If I may add, we want to make sure that your subcommittee knows that was approved by the House of Delegates of the AMA and referred to the Board of Trustees for action along with another resolution, Resolution 99, which essentially said that physicians who claim to be board certified should have to state the board which has certified them.

That particular step in the AMA procedure, approval and referral to the Board of Trustees for action, is the AMA's shorthand way of saying not only do we approve this, but we would like to see you do something about it soon.

Mr. Engel. Well, I think it goes back to what I said in my opening statement, where I felt that the vast majority of doctors are responsible and really want to weed out the rotten apples from their ranks. Personally, I think it says a lot for the AMA to approve this and the resolution that you have just mentioned.

Dr. Weary, which of the 23-member boards of the ABMS are you a member of?

Dr. Weary. The American Board of Dermatology.

Mr. Engel. As a member of that board, one would assume that you are fully qualified to perform many cosmetic surgery procedures, is that true?

Dr. Weary. No; that is not true.

Mr. Engel. Not true?

Dr. Weary. Because many of the things that are done as cosmetic procedures, we do not necessarily receive highly specialized training in. For instance, there is a procedure called Mohs micrographic surgery, which is a very highly specialized procedure, a surgical procedure done very much now. It is not a cosmetic procedure. It is dealing with skin cancer. I was never trained in that. I would never want to do that. I was never trained in hair transplantation, and I would not ever want to do that unless I took some additional training in which I were able to learn how to do it well.

I do very little cosmetic work. I do a lot of excisional surgery. I do a lot of cryosurgery, but I don't do much of what you would call cosmetic surgery. I think that dermatologists have been increasingly trained in recent years in much more sophisticated surgery, and there are strong efforts on the part of our board to encourage better teaching of dermatologic surgery by training programs.

Mr. **Engel.** Could you tell the committee which cosmetic procedures are taught at your university's dermatology department?

Dr. **Weary.** At the present time we are teaching our students about various cosmetic procedures, but we are not necessarily giving them explicit instruction or practice in doing that. Our feeling in our department, and this varies from department to department, I think you have to understand that, Mr. Chairman, our feeling is that what we want our residents to learn is when it is appropriate to do these things, what are the reasons why they might be done, and what are some of the reasons why they might not be done, what are the hazards involved, what are the expected outcomes that one might encounter, who are appropriate individuals on whom to consider this, and various things, so that they will at least be better informed.

Now, if they wish when they finish residency training to learn more about this, then I would encourage them to take additional training in these procedures. For instance, the Mohs micrographic surgery is done post-residency. It is usually a 1- to 2-year fellowship that is done after residency training. But at least my residents, when they finish, will know the indications for the use of Mohs micrographic surgery. My residents will not be trained to do that. They will have seen it done. They will not be trained to do it, but they will know when it is appropriate to do it and some of the problems that might arise. So, we are giving them a basic understanding, but we are not necessarily training them in all of these highly specialized procedures.

Mr. **Engel.** Does a doctor striving to be a board certified dermatologist learn the proper techniques of performing such procedures as facelifts, tummy tucks, breast reductions and enlargements?

Dr. **Weary.** I don't think that the dermatology training programs that I know of are teaching residents to do most of those procedures that you mention. Facelifts can be done and some dermatologists do these, but most of them have taken additional training after residency before they do that.

Mr. **Engel.** That is where some of the doctors who are doing them get the training?

Dr. **Weary.** Well, they are taking training in various ways. They may take a fellowship period of time. They may take a course in this. It depends on the procedure. It depends on the complexity. As I say, the Mohs micrographic surgery is at least a 1-year training program, and in many instances now it will probably go to 2 years. During the course of that training some of these individuals will also take additional training in some of the other things that you mention, hair transplantation and so forth.

In some training programs they are being taught more than in ours as to how to do these, and some of these residents coming out may have had considerably more experience in some of these procedures than our residents do. But that is a variation within residency training programs.

Mr. ENGEL. Just for the record, does the American Board of Dermatology condone and approve of its members advertising then that they are performing such cosmetic procedures as tummy tucks and breast implants?

Dr. WEARY. Well, you have to understand that I am the immediate past president of the American Board of Dermatology, and so, I cannot speak for what has happened in the past year since my term with the American Board of Dermatology is over, but at the present time I know of no position that the American Board of Dermatology has taken with respect to advertising one way or another.

Mr. ENGEL. Do you personally feel that dermatologists should be doing these procedures?

Dr. WEARY. The breast implantations and that sort of thing?

Mr. ENGEL. And tummy tuck.

Dr. WEARY. No; I do not. But there are some probably who are doing it, and they may have taken additional training, but it is not something that I think the general dermatologist would be qualified to do.

Mr. ENGEL. Thank you. Dr. Langsley, in January you told the subcommittee, and I am going to quote you. You said, "To most citizens, being board certified means that a physician has achieved a high level of specialist competence by virtue of training and successful completion of a rigorous examination." That was your quote.

Dr. LANGSLEY. That is correct, sir.

Mr. ENGEL. Would you agree, though, that the term "board certified" over the last decade has been diluted by false and deceptive advertising to the point that rather than the Good Housekeeping Seal of Approval that they can lead even to death at the hands of unqualified, unscrupulous people doing these operations?

Dr. LANGSLEY. I am afraid that is the truth.

Mr. ENGEL. In January, Doctor, you wrote the subcommittee that the term "board certified" is meaningful only if the public can be assured that the board has met high standards and has a process to offer assurance of accredited training and successful completion of a rigorous evaluation.

I would like you to state for the record, do you still believe that statement, and why is it so important to have independent review of these board requirements?

Dr. LANGSLEY. I still, of course, do believe that statement, Mr. Chairman. I think it is important, because for a physician to simply go to an organization that calls itself a board and say I have had experience in doing these procedures or this type of practice, and then have the board with or without some kind of written exam—people can study and pass written cognitive exams, but they don't necessarily demonstrate skill. Without having this kind of——

Mr. ENGEL. I might say it is the same thing in the law profession as well. Excuse me. I couldn't resist.

Dr. LANGSLEY. I don't blame you, sir. I tease my daughter, who is a lawyer, about the same thing, Mr. Chairman.

Therefore, I think that it is necessary for the process that we have set up for some kind of external review. I think that any organization that wants to call itself a board requires a review too. That is why in 1934 we set up the LCSB, and why we established criteria and standards.

We are talking about, with all due respect to the legal profession, there are not always in the legal profession the same kinds of life or death decisions, although it is an important profession and obviously influences life and death decisions. But in medicine those of us who come to this profession feel that we have to establish and maintain the highest possible standards. That is the meaning of medical care.

Mr. **Engel**. You mentioned the unfortunate fact that any individual or group can organize a board, issue certificates under any requirements it establishes, but those standards can vary dramatically from the valid credit card offered by the rigorous requirements of the 23 boards that are members of the ABMS. Why does the medical community let this deception occur and continue? Obviously, they are trying to do something about it. But why has it been so difficult?

Dr. **Weary**. Well, I think that were the medical profession to say that only those certified by ABMS certifying boards would be allowed to practice medicine or would be allowed to do certain things would probably be viewed by the Federal Trade Commission as a significant restraint of trade. As I said earlier, I think to simply condemn outright all self-designated boards is a matter of error. Because, as we said, there are some self-designated boards which have reasonably high standards comparable to those of ABMS boards.

I think another thing that is very important to keep in mind is the fact that we view the whole process of board certification as continuing to evolve. A good deal of the effort of the ABMS and the member boards is devoted to trying to improve our process so it will be more meaningful, so it will be more germane to the actual qualifications of the individual, to improve our examination process, so that when we do credential, we have increasing confidence that what we are doing will really accurately reflect the true qualifications of these individuals.

I think that one of the things that is so important about ABMS is that it is an organization that is continuing to seek a way to measure quality. It is an elusive feature, but I think we continue to seek it, and we are continuing to try to improve.

Mr. **Engel**. It gets back to the FTC again, and we had a previous hearing on the whole FTC issue and mentioned it. Again, for the record, do you believe that patients are being hurt because of the FTC's failure to do the job?

Dr. **Weary**. Well, I have heard a lot of testimony to that effect, and I know that certainly a number of people have so testified. I guess I feel that the Federal Trade Commission has to some extent emphasized the rights of the individual versus the rights of society. It has, perhaps, put more emphasis on the rights of the individual versus the rights of society, and in so doing, perhaps, the rights of society have not been adequately addressed, and in trying to increase competition, I think the rights of society may have been overlooked to some extent. I don't think I would like to say that I really believe one way or another because I think there is a lot of information we don't have, and I don't like to make statements without really having more information than that.

Mr. ENGEL. Turning to the list of the 105 known self-designated boards, we have talked about them. It appears that a number of them, obviously, refer to cosmetic surgery. As the experts in board certification requirements in the country that you are, could you tell us if any of those boards ever applied to the ABMS for certification?

Dr. WEARY. None of the other boards to our knowledge have ever applied to the Liaison Committee for Specialty Boards. This is where they would apply.

Mr. ENGEL. Why would a board not apply for membership?

Dr. WEARY. It would be sheer speculation on my part. I have no way of knowing. There may be a dozen different reasons, one of which may be they may feel that, knowing the requirements, the essentials that have been set forth by the LCSB that they would not qualify. That may be one of the major reasons. But I could speculate on a number of different reasons why that might be so, but I can't tell you.

Dr. LANGSLEY. If I could add to that.

Mr. ENGEL. Certainly.

Dr. LANGSLEY. One of the important requirements for approval by the LCSB, for approval of a new board is that there be a demonstration of adequate full-time training over a period of—presently it is anywhere from 3 to 7 years, full-time training, supervised training in an accredited hospital, in order for this field to be considered one worthy of recognition of a board. That is very different, Mr. Chairman, from some weekend courses, or studying by one's self, or a preceptorship. I think it is this requirement for full-time supervised training where the skills of a trainee are observed day-in and day-out that lends credence to some of the standards which the LCSB and the ABMS have established.

Don't you think so, Dr. Weary?

Dr. WEARY. Yes; definitely.

Mr. ENGEL. Have you heard of instances of self-taught cosmetic surgeons out there, where people obviously have not had any training but are performing these—they just have a medical degree?

Dr. WEARY. Well, you have to understand that any new type of procedure has to be self-taught. For instance, when the procedure of hair transplantation was first developed—I think it was by Dr. Norman Orntracht in New York—nobody was doing it. He did it. He taught himself and then other individuals went and studied under him and learned how to do this, and read about it, and started doing the procedure. Every new procedure has to be self-taught, and in the early stages the procedure is oftentimes done on a preceptorship-type of basis. You do not have established residency training situations for, say, laser surgery when laser surgery first came in, or when liposuction first came in. All of these were oftentimes taught first on the basis of a preceptorship-type situation, not within approved residency training.

After a procedure gets to be well established, then oftentimes it is incorporated into existing residency training programs and adopted by them. But in the early stages it has to be a self-taught or at least a preceptorship-taught-type thing, rather than a formal organized course. So, I think that is the important thing to understand.

Mr. ENGEL. I want to thank both of you, first of all for your patience, and, second, for your testimony, and your answering the questions. It has been very enlightening to me and to all of us.

I just want to state for the record that we will leave the record open. We may have more questions that we will submit to you.

Dr. WEARY. We will be pleased to answer them, Mr. Chairman.

Mr. ENGEL. Thank you very, very much.

Dr. LANGSLEY. We thank you, Mr. Chairman, and we certainly appreciate and support the efforts that you are undertaking in order to improve medical care.

Mr. ENGEL. Thank you.

Having no other panelists, we can say that the hearing is now officially ended, 5 hours after it began. Thank you all.

[Whereupon, at 3:12 p.m., the subcommittee was adjourned, to reconvene, subject to the call of the Chair.]

APPENDIX

OFFICE-BASED SURGERY:
A PERSPECTIVE ON THE PAST AND PRESENT

Presented by

Edward S. Truppman, MD

President

American Association for Accreditation of
Ambulatory Plastic Surgery Facilities, Inc.
(AAAAPSF)

June 28, 1989

Subcommittee on Regulation, Business Opportunities and Energy
Committee on Small Business
U.S. House of Representatives

INTRODUCTION

As representatives of the American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), we appreciate the opportunity to express our perspective on the status of office-based surgery in the United States. Our Association was established specifically to assure patient safety in office-based surgical settings, and we have a broad data base on which we base both our concerns and potential solutions.

To provide context for these concerns, we must first review why AAAAPSF was established, and how it operates.

ORIGINS OF AAAAPSF

In 1977, the leaders of the American Society of Plastic and Reconstructive Surgeons (ASPRS) recognized an emerging trend toward increasing numbers of office-based procedures -- both in the specialty and in medicine in general. It is currently estimated that 50 percent of all cosmetic plastic surgery procedures are performed in doctors' offices. (Actually, this figure is based on board-certified plastic surgeons alone, and may be higher when the practices of other physicians are factored in. Physicians who perform plastic surgery but received their formal training in another specialty are much less likely to have appropriate hospital privileges.)

This trend towards office-based surgery was fueled by patients looking for cost savings and convenience. However, while the ASPRS acknowledged the value of these benefits, it also was concerned about the potential for substandard care. Since doctors operating in their offices were out of sight of the watchful eye of hospital peer review programs -- and since no formal standards existed to govern these facilities -- the possible dangers were obvious.

ASPRS formed an Office Surgery Committee and conducted several surveys to measure the extent of the trend and its impact. More than 200 plastic surgeons responded, and the results revealed a clear need for national standards and a peer evaluation program. Input from this core group of surgeons provided the initial foundation for the standards that were later developed.

In 1980, the AAAAPSF was incorporated as an independent entity, with the sole purpose of assuring patient safety in office-based plastic surgery. It works to fulfill this mission through objective facility evaluations, using national standards and inspectors who are respected, non-competing specialists in the field. These standards are "dynamic": As the "state of the art" changes in plastic surgery, so do the criteria for measuring quality.

Although other organizations have since sponsored similar programs for medicine in general, AAAAPSF was formed at a time when the government and consumers had yet to perceive the developing need. It has become the largest accrediting organization for office-based surgery facilities, and has been recognized and recommended by both the American Medical Association and the American College of Surgeons. In addition, its standards have been endorsed by 90 percent of private insurance carriers and many state Blue Cross/Blue Shield plans (including those in Georgia, Maryland, Nevada and -- soon -- California). Several states, including Georgia and Florida, have adopted or imitated our standards when developing local licensing programs for ambulatory surgical facilities.

To date, we oversee 304 approved facilities, with another 128 in various phases of the rigorous accreditation process.

ACCREDITATION PROCESS

To apply for accreditation by AAAAPSF, facilities must:

o Be owned and/or directed by physicians who are certified by the American Board of Plastic Surgery (or its Canadian equivalent), who have privileges to perform the same procedures in a hospital, and who adhere to the code of ethics adopted by the ASPRS.

o Participate in a quality assurance program that is sponsored by a Peer Review Organization, developed internally or established by a group of plastic surgeons.

o Display and adhere to a patients' "Bill of Rights."

o Be governed in accordance with AAAAPSF standards.

Facilities applying for accreditation by AAAAPSF are evaluated in six areas:

o Patient selection and care.

o Quality assurance.

o Personnel (including the surgeons).

o Equipment.

o Safety procedures and plant design, with the latter evaluated according to guidelines drafted by a nationally recognized and licensed architect.

o Administrative documentation.

These capabilities are evaluated based on a site visit by a AAAAPSF inspector and an assessment of the findings by an association panel.

INSPECTION

All AAAAPSF inspectors are plastic surgeons who are certified by the American Board of Plastic Surgery, and own or direct an accredited ambulatory facility. We believe the fact that inspectors are drawn from the applicants' own specialty promotes the most thorough examination and the most valuable learning experience.

To assure an objective, fair review, inspectors do not examine any facility located in their own communities, or that are staffed by a surgeon who served as examiner for their own facilities. In addition, applicants for accreditation are allowed to choose their inspector from a list of three AAAAPSF nominees. The findings of the chosen inspector are based on his or her responses to a detailed list of questions specified by the association, and are analyzed by the most neutral, objective mechanism possible: the computer.

When an inspector visits a facility, he or she evaluates the center's compliance with AAAAPSF standards and shares his or her experience and expertise with the center's staff. The inspector's findings are documented, then analyzed by the computer and submitted with a recommendation to the AAAAPSF's Operating Committee. The final decision on the facility's application is made by the Board of Directors, and may involve:

o Denial, in which case the applicant must re-apply at a later date and submit to another on-site inspection.

o Provisional approval, which is granted when the deficiencies found are relatively minor. In this case, applicants have up to 90 days to submit proof that the requested corrections have been made.

o Full, three-year accreditation based on the type of surgery performed.

All results of the inspection process are forwarded to applicants for their edification.

TYPES OF ACCREDITATION

Early in its development of the accreditation program, AAAAPSF recognized that differing levels of capability existed in office-based surgery facilities -- and rightly so. To accommodate this reality, three classes of accreditation were established:

- CLASS A -- Centers that perform only minor plastic surgery procedures using local, regional or topical anesthesia.
- CLASS B -- Centers that perform minor and major plastic surgery procedures using only intravenous or parenteral sedation, analgesia or dissociative drugs.
- CLASS C -- Centers that perform all types of plastic surgery procedures using all types of anesthesia, including general. External support of vital body functions may be required.

(Note: Operations in which body cavities are entered on an elective basis may not be performed in any of these types of facilities.)

A list of plastic surgery procedures was developed, with each one classified according to the facility category in which it is most safely performed. The types of procedures performed at a facility are noted during the on-site inspection. This information is used to determine the appropriate accreditation level for the center.

Quality standards for each of these accreditation categories are explained in a manual that is made available to surgeons who are planning new facilities, as well to physicians whose centers are already approved and are striving to stay in compliance. A copy of this manual, which also includes a model patients' bill of rights, is attached.

ACCREDITATION CYCLE

The accreditation process of AAAAPSF is based on a three-year cycle. The year in which the application is first received is marked by the site visit, analysis and accreditation decision as described. To date, 40 percent of all applicants have been approved for full accreditation (in the appropriate classification), 55 percent have been granted provisional status and 5 percent were denied.

However, the actual impact of the accreditation process is greater than the failure rate may imply. The development and promulgation of national standards have inspired outpatient surgical facilities to make improvements prior to filing their applications. The result: First-time applicants now are showing fewer and fewer deficiencies.

Once approved, accreditation is granted for a three-year period. However, during the second and third years, facility directors and staff must complete a self-evaluation, using the format included in the standards manual. The completed questionnaires must be submitted to the AAAAPSF office, where they are analyzed by the computer. The results are returned to the centers for use in enhancing the facilities' performance.

DIRECTIONS FOR THE FUTURE

To build on the success of our program, and extend it other specialties, the AAAAPSF has proposed the following to the American College of Surgeons:

o Creation of a Council of Accreditation Associations for Unispecialty Ambulatory Surgical Facilities.

o Development of tiered, generic standards for all unispecialty ambulatory surgical facilities.

o Formulation of specific standards for each specialty when necessary.

In response, the ACS has appointed a committee to study the impact of such a project, with plans for eventual implementation.

CONCLUSIONS

In our nine years of experience with evaluation of single-specialty ambulatory surgery facilities, we have observed a marked improvement in the quality of these centers. Fewer deficiencies are now evident among facilities who apply for the first time, as well as in those who seek renewal of their accreditation. We strongly believe this improvement is due to the development and implementation of voluntary, national standards for both the facilities and the surgeons who operate them.

By making it possible for patients to safely visit outpatient plastic surgery centers, we offer them enhanced convenience and dramatic cost savings: Compared to inpatient hospital visits, the cost of office-based surgery is often 60-75 percent less.

However, although the 1980 Omnibus Reconciliation Act recognizes the value of oupatient surgical facilities, the Health Care Financing Administration has not yet promulgated regulations to implement this portion of the law. To date, it has issued regulations only for outpatient surgery in hospitals and free-standing, multi-specialty facilities. Therefore, government programs such as Medicare and Medicaid do not yet routinely reimburse such facility costs unless the center has a state license or certificate of need. For patients covered by these programs, this means their care is priced at a higher level than that for the same treatment given private patients in office facilities. If we all have the same goal of providing quality care at the lowest reasonable cost, should not this oversight be corrected? It would benefit both the patient and the government.

As official representatives of the AAAAPSF, we are here to assist the committee in finding a solution to the problems it has identified. We strongly believe that through our combined expertise, the patients and public will be well served and protected.

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC.
ACCREDITATION OFFICE: 1202 ALLANSON ROAD, MUNDELEIN, ILLINOIS 60060/(312) 949-6058

For information, contact
Ed Stygar 312-949-6058

PLASTIC SURGEONS CALL FOR CONTROLS ON OFFICE SURGERY

WASHINGTON DC, JUNE 28 -- Warning that the growing number of operations performed in doctors' offices is placing patients at risk, an organization of plastic surgeons asked a government subcommittee Wednesday to impose restrictions on who performs such procedures and in what types of facilities.

"This trend towards office-based surgery has been fueled by patients looking for cost savings and convenience," says Edward Truppman, MD, president of the American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF). "Considering that office-based surgery can cut expenses by 60-75 percent, that's a good thing. However, the possible dangers are obvious when doctors operate in uninspected offices, out of sight of the watchful eye of peer reviewers."

Dr. Truppman testified along with Drs. Gustavo Colon and Robert Singer on June 28 to the House of Representatives' Subcommittee on Regulation, Business Opportunities and Energy. The subcommittee, chaired by Rep. Ron Wyden (D-OR), is leading an investigation into the risks associated with the "boom" in cosmetic surgery -- including misleading advertising, substandard facilities and unqualified practitioners.

"These risks are not just potential; they are real and have already resulted in patient harm," said Gustavo Colon, MD, vice

- MORE -

President
EDWARD S. TRUPPMAN, M.D.
No. Miami Beach, Florida

Vice President
GUSTAVO A. COLON, M.D.
Metairie, Louisiana

Secretary
EUGENE W. WORTON, M.D.
Los Angeles, California

Treasurer
JOHN L. KRAUSE, M.D.
Cherry Hill, New Jersey

SHERRELL J. ASTON, M.D.
New York, New York

SIMON FREDRICKS, M.D.
Houston, Texas

FREDERICK M. GRAZER, M.D.
Newport Beach, California

STANLEY A. KLATSKY, M.D.
Baltimore, Maryland

PAUL L. SCHNUR, M.D.
Tucson, Arizona

RICHARD H. WALDEN, M.D.
Mineola, New York

president of AAAAPSF. "For example, in one recent case, a physician performed liposuction in an office complex actually designed to be a birthing center. The absence of appropriate facilities and the doctor's lack of formal plastic surgery training resulted in the tragic deaths of two young women. Yet this physician and others like him attempt to build high-volume practices by using advertising that implies a guarantee of perfect results, fails to state the full nature of their training or misrepresents the quality of their facility."

Dr. Robert Singer, a member of the AAAAPSF's Operating Committee, adds that although these potential risks exist for all types of office-based surgical facilities, they are especially prevalent in the specialty of plastic surgery.

"As physicians from a wide variety of fields rush to practice a specialty perceived as fast-growing and lucrative, the doctor's office has become a haven free from outside scrutiny," Dr. Singer told the subcommittee. This is a tragedy for patients, said Dr. Singer, considering that office surgery can be conducted very safely when performed by an adequately trained physician in an appropriate facility.

The AAAAPSF was founded in 1980 to protect the public from these dangers. All facilities applying for accreditation must be owned and/or directed by physicians who are certified by the American Board of Plastic Surgery, and who have hospital privileges to perform the same procedures done in the office. In

- MORE -

addition, the facilities are inspected by a neutral evaluator, whose report is analyzed by a computer. Accreditation is granted for three-year cycles.

The AAAAPSF is the largest accrediting organization for office-based facilities, and has been recognized by both the American Medical Association and American College of Surgeons. Its standards have been endorsed by most private insurance carriers as well as many Blue Cross/Blue Shield plans.

In its testimony to the government subcommittee, the AAAAPSF officers called on the House of Representatives to take the following actions:

- Develop national standards governing all office-based surgical facilities and the surgeons who practice there, and implement them through national legislation and/or model statutes for states.
- Require these standards to be enforced on a mandatory basis by existing, nationally recognized accrediting organizations.
- Mandate peer review for physicians practicing in office-based facilities.
- Require malpractice insurance for physicians operating in their offices.
- Insist that physicians perform only those procedures in their offices that they have privileges to do in an accredited hospital.

- MORE -

o Ensure truth in advertising by limiting claims of "board certification" to those physicians certified by organizations recognized by the American Board of Medical Specialties. In addition, those doctors who are allowed to make this claim should be required to state the full name of the board that tested them.

"We plead with you to help us return order to the currently chaotic and potentially dangerous state of cosmetic, office-based surgery," concluded Dr. Singer. "There is no time to waste."

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6/89

ATTACHMENTS FOR DR. EDWARD S. TRUPPMAN'S TESTIMONY

ATTACHMENT I: AAAAPSF CRITERIA
  A: STANDARDS MANUAL
  B: CHECKLIST/QUESTIONNAIRE
  C: INSPECTORS MANUAL
  D: ARCHITECTURAL PAMPHLET
    (Design Considerations in Office Facilities
    by: Arthur Garikes, A.I.A.)
ATTACHMENT II: ASPRS FACT SHEET
  PERCENTAGE OF SURGERIES PERFORMED IN OFFICE
  BASED FACILITIES
ATTACHMENT III: QUALITY CONTROL IN AMBULATORY SURGERY
ATTACHMENT IV: AMERICAN MEDICAL ASSOCIATION
  ACTION ON PAYMENT TO FACILITIES
    RESOLUTION NUMBER 53
    RESOLUTION NUMBER 99
ATTACHMENT V: INSURANCE REIMBURSEMENTS FOR OFFICE BASED
FACILITIES
  A: MUTUAL OF OMAHA
  B: BLUE CROSS - OHIO
  C: BLUE CROSS - MARYLAND
ATTACHMENT VI: OMNIBUS RECONCILIATION ACT
  SECTION #934 & FEDERAL REGISTER ARTICLE -
  VOL. 46, #99, FRIDAY MAY 22, 1981

AAPSF
AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC.
ACCREDITATION OFFICE: 1202 ALLANSON ROAD, MUNDELEIN, ILLINOIS 60060/(312) 949-6058

DESIGN CONSIDERATIONS IN OFFICE FACILITIES

1. ***TO BUILD OR TO RENT?***

2. ***DESIGN PHILOSOPHY***

    A. Free standing Operating Suite

    B. Office/Operating Suite

    C. Single story

    D. Multi story

3. ***PROBLEMS WITH MULTI STORY RENTAL SPACE***

    A. Mechanical Systems

        1. Heating, ventilating and air conditioning

        2. Processed piping (gas, air, vac)

    B. Vertical Transportation

        1. Elevators

        2. Dumbwaiters

        3. Pneumatic tube

        4. Automated containers

    C. Electrical Service

        1. Primary service

        2. Emergency service

        3. Communications

        4. Radiographic equipment

        5. Monitoring systems

Arthur G. Garikes, A.I.A.
Garikes Wilson Atkinson, Inc., Architects
2509 7th Avenue South
Birmingham, Alabama 35233
205/252-9191

4. ***CODES AND STANDARDS***

See Appendix

5. ***REVIEW AGENCIES***

   A. City Building Inspection Department
   B. City or State Fire Marshal
   C. County Board of Health
   D. State Board of Health
   E. State Health Department
   F. Health Services Agencies
   G. U.S. Department of Health and Human Services

6. ***PROGRAMMING ELEMENTS***

   A. Administrative and Public
      1. Entrance
      2. Reception
      3. Waiting
      4. Toilets
      5. Interview Room(s)
      6. Offices
      7. Multipurpose
      8. Records
      9. Employee Facilities
      10. General Storage
   B. Clinical Facilities
      1. Examination Room(s)
      2. Treatment Room(s)
      3. Operating Room(s)
      4. Recovery Room(s)
      5. Recovery Lounge

C. Surgical Service Areas
  1. Nurses' Station(s)
  2. Supervisor's Office
  3. Sterilizing Facilities
  4. Drug Preparation
  5. Scrub Facilities
  6. Soiled Workroom
  7. Clean Workroom
  8. Anesthesia Storage
  9. Anesthesia Workrooms
  10. Medical Gas Storage
  11. Equipment Storage
  12. Locker/Toilet/Shower
  13. Patient Preparation
  14. Stretcher Park
  15. Janitor's Closet
  16. Crash Cart

D. Diagnostic Facilities
  1. Radiology Suite
    a. Radiographic Room
    b. Film Processing
    c. View and Administration
    d. Film Storage
    e. Dressing Areas

- 2. Laboratory Suite
  - a. Work Counter
  - b. Lavatory
  - c. Storage
  - d. Specimen Toilet
  - e. Blood Drawing
- E. Engineering Services
  - 1. Mechanical Equipment Rooms
  - 2. Storage Rooms
- F. Waste Processing
  - 1. Storage and Disposal
  - 2. Incineration (gas, electric, oil-fired)
  - 3. Compaction
  - 4. Containerization
- G. Details and Finishes
  - 1. Minimum Public Corridor width 5'-0"
  - 2. Minimum Operating Room Corridor width 8'-0"
  - 3. One-hour fire separation
  - 4. Two (2) exits to exterior
  - 5. Two (2) smoke compartments
  - 6. Two-way door hardware in patient toilets
  - 7. Swing-type doors except elevators
  - 8. Wrist blades or knee-operated handwashing

H. Fire Vestibules

   1. Dumbwaiters
   2. Conveyors
   3. Materials and handling systems
   4. Linen chute
   5. Rubbish chute

I. Ceiling Heights

   1. Minimum 8'-0"
   2. Exceptions:
      a. Machine Rooms - 2'-6" clear
      b. Operating Pooms
      c. Radiographic Rooms
      d. Corridors, storage, toilets - 7'-8" minimum
      e. Minimum clearance from floor 6'-8" to bottom of overhead I.V. holder.

J. Finishes

   1. Cubicle curtains and drapes
   2. Flame spread and smoke
   3. Conductive floors
   4. Easy maintenance
   5. Wall bases in clinical areas
   6. Ceilings cleanable without crevices
   7. Acoustical ceilings

See Appendix

K. Mechanical Requirements

1. Energy efficient
2. Test and Balance
3. Operating manuals and P.M. program
4. Insulation

See Appendix

L. Temperatures and Humidity

		Temp. F/C	% Humidity
1.	Operating Rooms	68-76/20-24	50-60
2.	Recovery Rooms	75/24	50-60
3.	Patient Area	75/24	
4.	Other	72/22	

M. Emergency Electrical

1. Emergency generator
2. Circuits for patient and personnel
3. Exit signs
4. Exit corridors
5. Selected equipment receptacles
6. Telephone equipment
7. Operating and Recovery heating
8. Elevator service
9. Ventilation of O.R.
10. Central suction
11. Fire pumps
12. Fire alarms

N. Plumbing Requirements

1. Non-absorptive acid-resistant
2. Blade handles general 4-1/2" blades
3. Blade handles clinical sinks 6" blades
4. Vacuum breakers (backflow preventors)
5. Clinical sink with integral trap
6. Fire extinguishing systems

GENERAL COMMENTS

1. The doctors' offices do not fall under the category of ambulatory health care centers, as defined by NFPA 99 and NFPA 101, if less than four patients at a time are subject to procedures requiring general anesthesia.

2. NFPA 99 addresses requirements for medical gases for medical offices, except for vacuum for which there are no stated criteria.

3. NFPA 99, Chapter 3, addresses requirements for essential electrical distribution for medical offices, where inhalation of anesthetics is administered.

4. NFPA 99 addresses no special ventilation or air distribution requirements for operating rooms in medical offices.

5. Confirm with your local Building Department that your facility is classified as business occupancy and that there are no special requirements for the operating and recovery rooms.

Guidelines for
Construction
and
Equipment of
Hospital and
Medical
Facilities

1987 Edition

GUIDELINES

The American Institute of Architects
Committee on
Architecture for Health
with assistance from
U.S. Department of Health and
Human Services
Public Health Service
Health Resources and
Services Administration
Bureau of Maternal and
Child Health and
Resources Development
Office of Health Facilities

The American Institute of Architects Press
Washington, D.C. 1987

1.5 Codes and Standards

A. Every health facility shall provide and maintain a safe environment for patients, personnel, and visitors.

B. References made in this document to appropriate model codes and standards do not, generally, duplicate wording of the referenced codes.

NFPA's standards, especially the NFPA 101, are the basic codes of reference; but other codes and/or standards may be included as part of these standards. In the absence of state or local requirements, the project shall also comply with approved nationally recognized building codes except as modified in the latest edition of the NFPA 101, and/or herein.

Design standards for insuring accessibility for the handicapped may be based upon either UFAS or ANSI A117.1, in accordance with the local authority having jurisdiction. Federally assisted construction shall comply with UFAS.

Referenced code material is contained in the issue current at the time of this publication. The latest revision of code material is usually a clarification of intent and/or general improvement in safety concepts and may be used as an explanatory document for earlier code editions. Questions of applicability should be addressed as the need occurs.

C. **Equivalency**

Insofar as practical, these model standards have been established to obtain a desired performance result. Prescriptive limitations, when given, such as exact minimum dimensions or quantities, describe a condition that is commonly recognized as a practical standard for normal operation. For example, reference to a room area is for patient, equipment, and staff activities; this avoids the need for complex descriptions of procedures for appropriate functional planning.

In all cases where specific limits are described, equivalent solutions will be acceptable if the authority having jurisdiction approves them as meeting the intent of these standards. *Nothing in this document shall be construed as restricting innovations that provide an equivalent level of performance with these standards in a manner other than that which is prescribed by this document, provided that no other safety element or system is compromised in order to establish equivalency.*

The National Bureau of Standards (NBS) has developed a procedure for HHS that determines equivalency to certain NFPA 101 requirements. The Fire Safety Evaluation System (FSES), as developed by the NBS and included in NFPA 101, appendix C, may be useful for evaluating existing facilities which may be affected by modernization. However, for purposes of these standards, the FSES shall not be used as a substitute for the basic NFPA 101 nor shall it be used as a design code for new construction or major renovation in existing facilities.

Where existing structural conditions make strict compliance with NFPA 101 impractical, results of the FSES evaluation shall be considered to allow for possible equivalencies, so long as the entire building passes the FSES evaluation.

D. English/Metric Measurements

Metric standards of measurement are the norm for most international commerce and are being used increasingly in health facilities in the United States. Where measurements are a part of this document, English units are given as the basic standards with metric units in parenthesis.

E. List of Referenced Codes and Standards

Codes and standards which have been referenced in whole or in part in the various sections of this document are listed below. Names and addresses of originators are also included for information. The issues available at the time of publication are used. Later issues will normally be acceptable where requirements for function and safety are not reduced; however, editions of different dates may have portions renumbered or retitled. Care must be taken to insure that appropriate sections are used.

American National Standards Institute. Standard A17.1 (ANSI A17.1), ***American National Standard Safety Code for Elevators, Dumbwaiters, Escalators, and Moving Stairs.***

American National Standards Institute. Standard A117.1 (ANSI A117.1), ***American Standard Specification for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped.***

American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE). ***Handbook of Fundamentals.***

American Society of Heating Refrigerating and Air Conditioning Engineers. Standard 52-76, (ASHRAE 52-76), ***Method of Testing Air Cleaning Devices Used in General Ventilation for Removing Particulate Matter.***

Building Officials and Codes Administrators International, Inc. ***The BOCA Basic Building Code.***

Building Officials and Codes Administrators International, Inc. ***The BOCA Basic Plumbing Code.***

Code of Federal Regulations. Title 10, parts 20 and 35, ***Handling of Nuclear Materials.***

Code of Federal Regulations. Title 29, part 1910, ***Employee Safety and Health.***

Compressed Gas Association (CGA). ***Standards for Medical-Surgical Vacuum Systems in Hospitals.***

DOP Penetration Test Method. MIL, STD no. 282, ***Filter Units, Protective Clothing, Gas-Masking Components and Related Products: Performance Test Methods.***

General Services Administration, Department of Defense, Department of Housing and Urban Development, U.S. Postal Service. ***Uniform Federal Accessibility Standard*** (UFAS).

Health Education and Welfare. HEW publication no. (FDA)78-2081. (available through GPO), ***Food Service Sanitation Manual.***

Hydronics Institute. ***Boiler Ratings: I-B-R, Cast Iron***, and ***SBI Steel Boilers.***

Illuminating Engineering Society of North America. IESNA publication CP29, ***Lighting for Health Facilities.***

International Conference of Building Officials (ICBO). ***Uniform Building Code.***

National Association of Plumbing-Heating-Cooling Contractors (PHCC). ***National Standard Plumbing Code.***

National Council on Radiation Protection (NCRP). ***Medical X-ray and Gamma Ray Protection for Energies Up to 10 MeV Equipment Design and Use.***

National Council on Radiation Protection (NCRP). ***Radiation Protection Design Guidelines for 0.1-100, MeV Particle Accelerator Facilities.***

National Council on Radiation Protection (NCRP). ***Medical X-ray and Gamma Ray Protection for Energies up to 10 MeV Structural Shielding Design and Evaluation.***

National Bureau of Standards Interagency Report. NBSIR 81-2195, ***Draft Seismic Standards for Federal Buildings Prepared by Interagency Committee on Seismic Safety in Construction*** (available from NTIS as no. PB81-163842).

National Fire Protection Association. Standard 20 (NFPA 20), ***Centrifugal Fire Pumps.***

NFPA 70. ***National Electrical Code.***

NFPA 72A. *Standard for the Installation, Maintenance, and Use of Local Protectives Signaling Systems.*

NFPA 72E. *Standard for Automatic Fire Detectors.*

NFPA 80. *Standard for Fire Doors and Windows.*

NFPA 82. *Standard on Incinerators, Waste and Linen Handling Systems and Equipment.*

NFPA 90A. *Standard for the Installation of Air Conditioning and Ventilation Systems.*

NFPA 96. *Standard for the Installation of Equipment for the Removal of Smoke and Grease-Laden Vapors from Commercial Cooking Equipment.*

NFPA 99. "Use of Inhalation Anesthetics (Flammable and Nonflammable)," *Standard for Health Care Facilities*, chap. 3, formerly NFPA 56A.

NFPA 99. "Laboratories in Health Related Institutions," *Standard for Health Care Facilities*, chap. 7, formerly NFPA 56C.

NFPA 99. "Standard for Nonflammable Medical Gas Systems," *Standard for Health Care Facilities*, formerly NFPA 56E.

NFPA 99. "Essential Electrical Systems for Health Care Facilities," *Standard for Health Care Facilities*, chap. 8, formerly NFPA 76A.

NFPA 99. "Safe Use of Electricity in Patient Care Areas of Hospitals," *Standard for Health Care Facilities*, chap. 9, formerly NFPA 76B.

NFPA 101. *Life Safety Code.*

NFPA 110. *Emergency and Standby Power Systems.*

NFPA 253. *Standard Method for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source.*

NFPA 255. *Method of Test Surface Burning Characteristics of Building Materials.*

NFPA 258. *Standard Research Test Method for Determining the Smoke Generation of Solid Materials.*

NFPA 701. *Standard Method of Fire Tests for Flame Resistant Textiles and Films.*

NFPA 801. *Recommended Fire Protection Practice for Facilities Handling Radioactive Materials.*

Southern Building Code Congress International, Inc. *Standard Building Code.*

Underwriter's Laboratories, Inc. Publication no. 181.

F. Availability of Codes and Standards

The codes and standards referenced in various sections throughout this document can be ordered, if they are government publications, from the Superintendent of Documents, U.S. Government Printing Office (GPO), Washington, D.C. 20402. Copies of nongovernment publications can be obtained at the addresses listed below.

Air Conditioning and Refrigeration Institute
1501 Wilson Blvd.
Arlington, Va. 22209

American National Standards Institute
1430 Broadway
New York, N.Y. 10018

American Society for Testing and Materials
1916 Race Street
Philadelphia, Pa. 19103

American Society of Heating, Refrigerating, and Air-Conditioning Engineers
1741 Tullie Circle, NE
Atlanta, Ga. 30329

Architectural and Transportation Barriers
Compliance Board (ATBCB)
Office of Technical Services
330 C Street, SW
Washington, D.C. 20202

Building Officials and Code Administrators
4051 West Flossmoor Road
Country Club Hills, Ill. 60477

Compressed Gas Association
1235 Jefferson-Davis Highway
Arlington, Va. 22202

Hydronics Institute
35 Russo Place
Berkeley Heights, N.J. 07922

Illuminating Engineering Society of North America
(IESNA)
IES Publication Sales
345 East 47th Street
New York, N.Y. 10017

International Conference of Building Officials
5360 South Workman Mill Road
Whittier, Calif. 90601

National Association of Plumbing-Heating-Cooling
Contractors
~~Box 6808~~
180 S. Washington Street
Falls Church, Va. 22046

National Council on Radiation Protection and
Measurement
7910 Woodmont Avenue, Suite 1016
Bethesda, Md. 20814

National Fire Protection Association
Batterymarch Park
Quincy, Mass. 02264

National Technical Information System (NTIS)
5285 Port Royal Road
Springfield, Va. 22161

Naval Publications and Form Center
5801 Tabor Avenue
Philadelphia, Pa. 19120
(for DOP Penetration Test Method)

Southern Building Code Congress International, Inc.
900 Montclair Road
Birmingham, Ala. 35213

Underwriter's Laboratories, Inc.
333 Pfingsten Road
Northbrook, Il. 60062

Table 3

Ventilation Requirements for Areas Affecting Patient Care in Hospitals, Skilled Nursing, Outpatient, and Rehabilitation Facilities[1]

Area designation	Air movement relationship to adjacent area[2]	Minimum air changes outside air per hour[3]	Minimum total air changes per hour[8]	Recirculated by means of room units[4]	All air exhausted directly outdoors[5]	Relative humidity (%)[6]	Design temperature (degrees)[7]
Operating rooms	Out	3	15	No	—	50–60	70–75
Delivery rooms	Out	3	15	No	—	45–60	70–75
X-ray card. cath. and interv. spec. proc.	Out	3	15	No	—	45–60	70–75
Newborn nursery	—	1	6	No	—	30–60	75
Recovery rooms	—	2	4	No	—	30–60	70
Intensive care	—	2	6	No	—	30–60	70–75
Isolation rooms	In	—	6	No	Yes	—	70–75
Isolation alcove or anteroom	Out	—	10	No	Yes	—	—
Patient room	—	—	2	—	—	—	70–75
Labor delivery rooms (LDR)	—	—	2	—	—	—	70–75
Patient corridor	—	—	2	—	—	—	—
Examination room	—	—	6	—	—	—	75
Medication room	—	—	4	—	—	—	—
Pharmacy	—	—	4	—	—	—	—
Treatment rooms	—	—	6	—	—	—	75
Trauma rooms	Out	3	15	No	—	45–60	70–75
X-ray rm. and noninterv. spec. proc.	—	—	6	—	—	—	75
Physical Rx							
Hydrotherapy	In	—	6	—	—	—	75
Treatment room	—	—	6	—	—	—	70–75
Soiled utility	In	—	10	No	Yes	—	—
Clean utility	—	—	4	—	—	—	—
Autopsy room	In	—	12	No	Yes	—	—
Darkroom	In	—	10	No	Yes	—	—
Nonrefrigerated body-holding room	In	—	10	Yes	Yes	—	70
Toilet room	In	—	10	Yes	Yes	—	—
Bedpan room	In	—	10	Yes	Yes	—	—

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[1] This table covers ventilation for comfort, as well as for asepsis and odor control in areas of acute care hospitals that directly affect patient care. Areas where specific standards are not given shall be ventilated in accordance with ASHRAE Standard 62-1981, "Ventilation for Acceptable Indoor Air Quality Including Requirements for Outside Air." Specialized patient care areas including organ transplant units, burn units, specialty procedure rooms, etc., shall have additional ventilation provisions for air quality control as may be appropriate. OSHA standards and/or NIOSH criteria require special ventilation requirements for employee health and safety within health care facilities.

[2] Design of the ventilation system shall, insofar as possible, provide that air movement is from "clean to less clean" areas. However, continuous compliance may be impractical with full utilization of some forms of variable air volume and load shedding systems which may be used for energy conservation. Areas which do require positive and continuous control are noted with "out" or "in" to indicate the required direction of air movement in relation to the space named (this designation was previously described as "positive" or "negative" pressure). Rate of air movement may, of course, be varied as needed within the limits required for positive control. Where indication of air movement direction is enclosed in parentheses, continuous directional control is required only when the tool is in use or where room use may otherwise compromise the intent of movement from clean to less clean. Air movement for rooms with dashes and nonpatient areas may vary as necessary to satisfy the requirements. Additional adjustments may be needed when space is unused or unoccupied and air systems are shut down or reduced.

[3] To satisfy exhaust needs, replacement air from outside is necessary. Table 3 does not attempt to describe specific amounts of outside air to be supplied to individual spaces except for certain areas such as those listed. Distribution of the outside air, added to the system to balance required exhaust, shall be as required by good engineering practice.

[4] Because of cleaning difficulty and potential for buildup of contamination, recirculating room units shall not be used in areas marked "No." Isolation and intensive care unit rooms may be ventilated by reheat induction units in which only the primary air supplied from a central system passes through the reheat unit. Gravity-type heating or cooling units such as radiators or convectors shall not be used in operating rooms and other special care areas.

[5] Air from areas with contamination and/or odor problems shall be exhausted to the outside and not recirculated to other areas. Note that individual circumstances may require special consideration for air exhaust to outside, e.g., an intensive care unit in which patients with pulmonary infection are treated, and rooms for burn patients.

[6] The ranges listed are the minimum and maximum limits where control is specifically needed.

[7] Dual temperature indications (such as 70–75) are for an upper and lower variable range at which the room temperature must be controlled. A single figure indicates a heating or cooling capacity of at least the indicated temperature. This is usually applicable when patients may be undressed and require a warmer environment. Nothing in this document shall be construed as precluding the use of temperatures lower than those noted when the patients' comfort and medical conditions make lower temperatures desirable. Unoccupied areas such as storage, etc., shall have temperatures appropriate for the function intended.

[8] Number of air changes may be reduced when the room is unoccupied if provisions are made to insure that the number of air changes indicated is reestablished any time the space is being utilized. Adjustments shall include provisions so that the direction of air movement shall remain the same when the number of air changes is reduced. Areas not indicated as having continuous directional control may have ventilation systems shut down when space is unoccupied and ventilation is not otherwise needed.

Table 3 (Continued)

Ventilation Requirements for Areas Affecting Patient Care in Hospitals, Skilled Nursing, Outpatient, and Rehabilitation Facilities[1]

Area designation	Air movement relationship to adjacent area[2]	Minimum air changes of outside air per hour[3]	Minimum total air changes per hour[4]	Recirculated by means of room units[5]	All air exhausted directly outdoors[6]	Relative humidity (%)[7]	Design temperature (degrees)[8]
Bathroom	—	—	10	—	—	—	75
Janitors closet	In	—	10	No	Yes	—	—
Sterilizer equipment room[13]	In	—	10	—	Yes	—	—
ETO-sterilizer room[13]	In	—	10	No	Yes	—	75
Soiled linen and trash rooms	In	—	10	No	Yes	—	—
Laboratory							
General[16]	—	—	6	—	—	—	—
Nuclear medicine[15]	In	—	6	No	Yes	—	—
Pathology	In	—	6	No	Yes	—	—
Cytology	In	—	6	No	Yes	—	—
Biochemistry[16]	Out	—	6	No	—	—	—
Histology	In	—	6	No	Yes	—	—
Microbiology[16]	In	—	6	No	Yes	—	—
Serology	Out	—	6	No	—	—	—
Glass washing	In	—	10	—	Yes	—	—
Sterilizing	In	—	10	—	Yes	—	—
Food preparation centers[11]	—	—	10	No	—	—	—
Ware washing	In	—	10	No	Yes	—	—
Dietary day storage	In	—	2	—	—	—	—
Laundry, general	—	—	10	—	Yes	—	—
Soiled linen (sorting and storage)	In	—	10	No	Yes	—	—
Clean linen	—	—	2	—	—	—	—
Anesthesia gas storage[14]	—	—	8	—	Yes	—	—
Central supply							
Soiled room	In	—	6	No	Yes	—	—
Clean workroom and sterile storage	Out	—	4	No	—	(max) 70	75

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[9] The term *trauma room* as used here is the operating room space in the emergency department, or other trauma reception area that is used for emergency surgery. The first aid room and/or "emergency room" used for initial treatment of accident victims may be ventilated as noted for the "treatment room."

[10] The isolation rooms described in these standards are those that might be utilized in the average community hospital. The assumption is made that most isolation procedures will be for infectious patients and that the room should also be suitable for normal private patient use when not needed for isolation. This compromise obviously does not provide for ideal isolation. The design should consider types and numbers of patients that might need this separation within the facility. When need is indicated by the program, it may be desirable to provide more complete control with a separate anteroom as an air lock to minimize potential for airborne particulates from the patients' area reaching adjacent areas. Certain types of patients such as those with organ transplants, burns, etc., may require special consideration, including reverse isolation for which the air movement relationship to adjacent areas would be "out" rather than "in." Where these requirements are reflected in the anticipated patient load, ventilation shall be modified as necessary. *Variable exhaust that allows maximum room space flexibility with reversible air flow direction would be useful only if appropriate adjustments can be assured for different types of isolation procedures.*

[11] Food preparation centers shall have ventilation systems that have an excess of air supply for "out" air movements when hoods are not in operation. The number of air changes may be reduced or varied to any extent required for odor control when the space is not in use. See section 7.31D(1)(p) of this document for designation of hoods.

[12] A nonrefrigerated body-holding room would be applicable only for health care facilities in which autopsies are not performed on-site, or the space is used only for holding bodies for short periods prior to transferring.

[13] Specific OSHA regulations regarding ethylene oxide (ETO) use have been promulgated. 29 CFR Part 1910.1047 includes specific ventilation requirements including local exhaust of the ETO sterilizer area. Also, see section 7.31D(1)(r) of this document.

[14] National Institute of Occupational Safety and Health (NIOSH) Criteria Documents regarding Occupational Exposure to Waste Anesthetic Gases and Vapors, and Control of Occupational Exposure to Nitrous Oxide indicate a need for both local exhaust (scavenging) systems and general ventilation of the areas in which the respective gases are utilized.

[15] Large hospitals may have separate departments for diagnostic and therapeutic radiology and nuclear medicine. For specific information on radiation precautions and handling of nuclear materials, refer to appropriate publication of National Radiation Safety Council and Nuclear Regulatory Commission. Special requirements are imposed by the U.S. Nuclear Regulatory Commission (Regulatory Guide 10.8-1980) regarding use of Xenon-133 gas.

[16] When required, appropriate hoods and exhaust devices for the removal of noxious gases shall be provided (see section 7.31D(1)(o) and NFPA 99).

9. OUTPATIENT FACILITIES

9.1 General

A. Section Applicability

This section applies to the outpatient unit, which may be a separate freestanding facility within a nonmedical facility or part of a health maintenance organization (HMO) or other health service. This section does not apply to the offices of private-practice physicians in commercial office space and should not be applied to such offices in ancillary outpatient facilities. Specifically described are:

1. Primary Care Outpatient Center (section 9.3).
2. The Small Primary (Neighborhood) Outpatient Facility (section 9.4).
3. The Outpatient Surgical Facility (section 9.5)
4. The Freestanding Emergency Facility (section 9.6).

The general standards set forth in sections 9.1 and 9.2 apply to each of the above. Additions and/or modifications shall be made as described for the specific facility type. (See section 7 for emergency and outpatient services that are part of the general hospital.)

Specialty facilities such as those for renal dialysis, cancer treatment, mental health, rehabilitation etc., have needs that are not addressed here. They must satisfy additional conditions to meet respective programs standards.

B. Outpatient Facility Classification

Except for the emergency unit, the outpatient facilities described herein used primarily by patients capable of traveling into, around, and out of the facility unassisted. This includes the handicapped confined to wheelchairs. Occasional facility use by stretcher patients should not be used as a basis for more restrictive institutional occupancy classifications.

Facilities shall comply with the "Ambulatory Health Care Centers" section of NFPA 101, in addition to details herein, where patients incapable of self-preservation or those receiving inhalation anesthesia are treated. The "Business Occupancy" section of NFPA 101 applies to other types of outpatient facilities. Outpatient units that are part of another facility may be subject to the additional requirements of the other occupancy.

References are made to section 7, "General Hospital," for certain service spaces such as the operating rooms of the outpatient surgical unit. Those references are intended only for the specific areas indicated.

C. Facility Access

Where the outpatient unit is part of another facility, separation and access shall be maintained as described in NFPA 101. Building entrances used to reach the outpatient services shall be at grade level, clearly marked, and located so that patients need not go through other activity areas. (Lobbies of multioccupancy buildings may be shared.) Design shall preclude unrelated traffic within the unit.

D. Functional Program Provision

Each project sponsor shall provide a functional program for the facility. (See section 1.1F of this document.)

E. Shared/Purchased Services

When services are shared or purchased, space and equipment should be modified or eliminated to avoid unnecessary duplication.

F. Location

Community outpatient units shall be conveniently accessible to patients and staff via available public transportation.

G. Parking

In the absence of a formal parking study, parking for outpatient facilities shall be provided at the rate noted for each type of unit. On-street parking, if available, may satisfy part of this requirement unless described otherwise. If the facility is located in a densely populated area where a large percentage of patients arrive as pedestrians; or if adequate public parking is available nearby; or if the facility is conveniently accessible via public transportation, adjustments to this standard may be made with approval of the appropriate authorities.

H. Access for Handicapped

All outpatient facilities shall be accessible to and usable by handicapped employees, staff, visitors, and patients. (See section 1.3 of this document.)

I. Privacy for Patients

Each facility design shall ensure patient privacy and dignity during interviews, examinations, and treatment.

9.2 Common Elements for Outpatient Facilities

The following shall apply to each outpatient facility described herein with additions and/or modifications as noted for each specific type. Special consideration shall be given to needs of children for pediatric services.

A. Administration and Public Areas

1. Entrance. Located at grade level and able to accommodate wheelchairs.

2. Public services shall include:

a. Conveniently accessible wheelchair storage.

b. A reception and information counter or desk.

c. Waiting space(s). Where an organized pediatric service is part of the outpatient facility, provisions shall be made for separating pediatric and adult patients.

d. Conveniently accessible public toilets.

e. Conveniently accessible public telephone(s).

f. Conveniently accessible drinking fountain(s).

3. Interview space(s) for private interviews related to social service, credit, etc., shall be provided.

4. General or individual office(s) for business transactions, records, administrative, and professional staffs shall be provided.

5. Clerical space or rooms for typing, clerical work, and filing, separated from public areas for confidentiality, shall be provided.

6. Multipurpose room(s) equipped for visual aids shall be provided for conferences, meetings, and health education purposes.

7. Special storage for staff personal effects with locking drawers or cabinets (may be individual desks or cabinets) shall be provided. Such storage shall be near individual work stations and staff controlled.

8. General storage facilities for supplies and equipment shall be provided as needed for continuing operation.

B. Clinical Facilities

As needed, the following elements shall be provided for clinical services to satisfy the functional program:

1. General purpose examination room(s). For medical, obstetrical, and similar examinations, rooms shall have a minimum floor area of 80 square feet (7.43 square meters), excluding vestibules, toilets, and closets. Room arrangement should permit at least 2 feet 8 inches (81.3 centimeters) clearance at each side and at the foot of the examination table. A lavatory or sink for handwashing and a counter or shelf space for writing shall be provided.

2. Special purpose examination rooms. Rooms for special clinics such as eye, ear, nose, and throat examinations, if provided, shall be designed and out-

Table 7
Flame-Spread and Smoke-Production Limitations on Interior Finishes

	Flame-spread rating	Smoke-production rating
Walls and ceiling		
Exitways, storage rooms, and areas of unusual fire hazard	25 or less (ASTM E84)	450 or less* (NFPA 258)
All other areas	75 or less (ASTM E84)	450 or less (NFPA 258)
Floors**		
Corridors and means of egress	Minimum of .45 watts/cm² (NFPA 253, Floor Radiant Panel Test)	

* Average of flaming and nonflaming values.

** See section 1.3 of this document for requirements relative to carpeting areas that may be subject to use by handicapped individuals. These areas include offices, waiting spaces, etc., as well as corridors that might be used by handicapped employees, visitors, or staff.

J. Provision for Disasters

Seismic-force resistance of new construction for outpatient facilities shall comply with section 1.4 of this document and shall be given an importance factor of one. Where the outpatient facility is part of an existing building, that facility shall comply with applicable local codes. Special design provisions shall be made for buildings in regions that have sustained loss of life or damage to buildings from hurricanes, tornados, floods, or other natural disasters.

K. Elevators

1. All buildings with patient or service areas on other than the grade-level main entrance floor shall have electric or hydraulic elevators. Installation and testing of elevators shall comply with UFAS or ANSI A117.1.

a. Cars shall have a minimum inside floor dimension of not less than 5 feet (1.52 meters).

b. Elevators shall be equipped with an automatic two-way leveling device with an accuracy of ± ½ inch (± 1.3 centimeters).

c. Elevator controls, alarm buttons, and telephones shall be accessible to wheelchair occupants and usable by the blind.

d. Heat-sensitive call buttons shall not be used. Where light beams are used to activate safety stops, these shall be in addition to door-edge stops and shall be deactivated by smoke detectors located at each landing.

2. Elevator inspections and tests shall be made. The owner shall be furnished with written certification that the installation meets all applicable safety regulations and codes and the standards set forth in this section.

L. Mechanical Standards

The following requirements shall apply to outpatient facilities that are freestanding; or within a nonmedical facility; or part of a health maintenance organization or other health service; or physically attached to a general hospital but independent of hospital areas, services, or equipment.

Where general hospital areas, services, and/or equipment are shared with the outpatient facility, the mechanical standards of section 7.31 of this document shall apply only to the specific areas, services, and/or equipment being shared (i.e., operating room, recovery room, etc.).

1. General mechanical systems standards are as follows:

a. The mechanical system should be subject to general review for overall efficiency and life-cycle cost. Details for cost-effective implementation of design features are interrelated and too numerous (as well as too basic) to list individually. Recognized engineering procedures shall be followed for the most economical and effective results. A well-designed system can generally achieve energy efficiency at minimal additional cost and simultaneously provide for improved patient comfort. Different geographic areas may have climatic variations and use conditions that favor one system over another in terms of overall cost and efficiency. For instance, adiabatic cooling and dead-load controls may be common designs for certain western states but relatively unknown elsewhere. In no case shall patient care or safety be sacrificed for conservation.

b. Remodeling and work in existing facilities may present special problems. As practicality and funding permit, existing insulation, weather stripping, etc., shall be brought up to standard for maximum economy and efficiency. Consideration shall be given to additional work that may be needed to achieve this.

c. Facility design considerations shall include site, building mass, orientation, configuration, fenestration, and other features relative to passive and active energy systems.

d. Insofar as practical, the facility shall include provisions for recovery of waste cooling and heating energy (ventilation, exhaust, water and steam discharge, cooling towers, incinerators, etc.).

e. Facility design shall include consideration of recognized procedures such as variable-air-volume systems, load shedding, programmed controls for unoccupied periods (nights and weekends, etc.), and use of natural ventilation, site and climatic conditions permitting. Systems with excessive operational and/or maintenance costs that negate long-range energy savings should be avoided.

f. Controls for air-handling systems shall be designed with an economizer cycle to use outside air for cooling and/or heating. (Use of mechanically circulated outside air does not reduce need for filtration.) It may be practical in many areas to reduce or shut down mechanical ventilation during appropriate climatic and patient-care conditions and to use open windows for ventilation.

g. Ventilation standards permit maximum use of simplified systems including those for variable-air-volume (VAV) supply. However, care must be taken in design to avoid possibility of large temperature differentials, high-velocity supply, excessive noise, and air stagnation, etc. Air supply and exhaust in rooms for which no minimum air change rate is noted may vary down to zero in response to room load. Temperature control shall also comply with these standards. To maintain asepsis control, airflow supply and exhaust should generally be controlled to insure movement of air from "clean" to "less clean" areas.

h. Prior to acceptance of the facility, all mechanical systems shall be tested, balanced, and operated to demonstrate to the design engineer or to his or her representative that the installation and performance of these systems conform to design intent. Test results shall be documented for maintenance files.

i. Upon completion of the equipment installation contract, the owner shall be furnished with a complete set of manufacturers' operating, maintenance, and preventive maintenance instructions, a parts lists, and complete procurement information including equipment numbers and descriptions. Operating staff persons shall also be provided with instructions for properly operating systems and equipment. Required information shall include energy ratings needed for future conservation calculations.

2. Thermal and acoustical insulation shall meet the following standards:

a. Insulation within the building shall be provided to conserve energy, protect personnel, prevent vapor condensation, and reduce noise and vibration for the following:

i. Boilers, smoke breeching, and stacks.
ii. Steam supply and condensate return piping.
iii. Heating, hot water supply, and return piping.
iv. Chilled water, refrigerant, and other process piping and equipment operating with fluid temperatures below ambient dew point.
v. Cold water supply and drainage piping on which condensation may occur.
vi. Domestic hot water piping, water heaters, tanks, generators, and converters.
vii. Heating, ventilating, air conditioning, and air-handling duct systems (including ducts, plenums, and casings) with surface temperatures 9°F (5°C) above or below the ambient dry-bulb or dew-point temperatures.
viii. Other piping, ducts, and equipment where applicable.

b. Insulation on cold surfaces shall include an exterior vapor barrier. (Material that will not absorb or transmit moisture need not have a separate vapor barrier.)

c. Insulation, including finishes and adhesives on the exterior surfaces of ducts and equipment, shall have a flame-spread rating of 25 or less and a smoke-developed rating of 50 or less as determined by an independent testing laboratory in accordance with NFPA 255. The smoke-development rating for pipe insulation shall not exceed 150. This includes mechanical refrigeration and distribution equipment and hot water distribution equipment such as valves, pumps, chillers, etc.

d. Use of duct linings is generally discouraged as they increase energy costs by increasing system-pressure drops. Moreover, remodeling of lined duct systems destroys the integrity of the liner sealant. However, if linings are used in nonsensitive hospital areas, they shall meet the erosion test method described in Underwriters' Laboratories, Inc., publication no. 181. These linings (including coatings, adhesives, and exterior surface insulation on pipes and ducts in spaces used as air supply plenums) shall have a flame-spread rating of 25 or less and a smoke-developed rating of 50 or less as determined by an independent testing laboratory in accordance with NFPA 255.

e. Duct lining exposed to air movement shall not be used in ducts serving operating rooms, delivery rooms, LDR rooms, and intensive care units. Where its use cannot be avoided, terminal filters of at least 90 percent efficiency shall be installed downstream of all lining material. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such linings.

f. Asbestos insulation shall not be used in health facilities.

g. Existing accessible insulation within areas of facilities to be modernized shall be inspected, repaired, and/or replaced, as appropriate.

3. Mechanical standards for steam and hot water systems (where used) are as follows:

a. Boilers shall have the capacity, based upon the net ratings published by the Hydronics Institute or another acceptable National Standard, to supply the normal heating, hot water, and steam requirements of all systems and equipment.

b. Boiler accessories including feed pumps/heating circulating pumps, condensate return pumps, fuel oil pumps, and waste heat boilers shall be connected and installed to provide both normal and standby service.

c. Supply and return mains and risers for cooling, heating, and steam systems shall be equipped with valves to isolate the various sections of each system. Each piece of the equipment shall have valves at the supply and return ends. However, vacuum condensate returns need not be valved at each piece of equipment.

4. Air conditioning, heating, and ventilating systems shall comply with the following standards:

a. The ventilation rates shown in table 3 shall be used only as model standards; they do not preclude the use of higher, more appropriate rates. All rooms and areas in the facility shall have provisions for ventilation. Though natural window ventilation for noncritical areas may be employed, weather permitting, mechanical ventilation should be considered for use in interior areas and during periods of temperature extremes. Fans serving exhaust systems shall be located at the discharge end and shall be readily serviceable. Exhaust systems may be combined to enhance the efficiency of recovery devices required for energy conservation.

- *i.* Facility design should utilize energy conserving mechanisms including recovery devices, variable air volume, load shedding, and systems to shut down or reduce ventilation of unoccupied areas, insofar as patient care is not compromised. When appropriate, mechanical ventilation should employ an economizer cycle that uses outside air to reduce heating- and cooling-system loads. Filtering requirements shall be met when outside air is used as part of the mechanical ventilation system. Innovative design that provides for additional energy conservation while meeting the intent of these standards for acceptable patient care should be considered (see appendix).
- *ii.* Fresh air intakes shall be located at least 25 feet (7.62 meters) from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vents, or areas that may collect vehicular exhaust or other noxious fumes. (Prevailing winds and/or proximity to other structures may require greater clearances.) Plumbing and vacuum vents that terminate at a level above the top of the air intake may be located as close as 10 feet (3.05 meters). The bottom of outdoor air intakes serving central systems shall be as high as practical, but at least 6 feet (1.83 meters) above ground level, or, if installed above the roof, 3 feet (91 centimeters) above the roof level. Exhaust outlets from areas that may be contaminated shall be above roof level and arranged to minimize recirculation of exhaust air into the building.
- *iii.* The ventilation systems shall be designed and balanced to provide directional flow as shown in table 3. (See also note 8 of table 3 for reductions and shutdown of ventilation systems during room vacancy.)
- *iv.* Operating room air supply shall be from ceiling outlets near the center of the work area for effective air movement control. Return air shall be from the floor level. Each operating room shall have at least two return air inlets located as remotely

from each other as practical. (Design should consider turbulence and other factors of air movement to minimize fall of particulates onto sterile surfaces.)

v. Each space routinely used for administering inhalation anesthesia shall be equipped with a scavenging system to vent waste gases. If a vacuum system is used, the gas-collecting system shall be arranged so that it does not disturb patients' respiratory systems. Gases from the scavenging system shall be exhausted directly to the outside. The anesthesia gas scavenging exhausts directly to the outside and is not part of the recirculation system. Separate scavenging systems are not required for areas where gases are used only occasionally, such as the emergency room, and offices for routine dental work, etc. Acceptable concentration of anesthetizing agents are unknown at this time. The absence of specific data makes it difficult to set specific standards. However, any scavenging system should be designed to remove as much of the gas as possible from the room environment. While not within the scope of this document, it is assumed that anesthetizing equipment will be selected and maintained to minimize leakage and contamination of room air.

vi. The bottoms of ventilation (supply/return) openings shall be at least 3 inches (7.6 centimeters) above the floor.

vii. All central ventilation or air conditioning systems shall be equipped with filters having efficiencies equal to, or greater than, those specified in table 8. Where two filter beds are used, filter bed no. 1 shall be located upstream of the air conditioning equipment and filter bed no. 2 shall be downstream of any fan or blower. Where only one filter bed is required, it shall be located upstream of the air conditioning equipment, unless an additional prefilter is used. In this case, the prefilter shall be upstream of the equipment and the main filter may be located further downstream. Filter efficiencies, tested in accordance with ASHRAE 52-76, shall be average, except as noted otherwise. Filter frames shall be durable and proportioned to provide an airtight fit with the enclosing ductwork. All joints between filter segments and enclosing ductwork shall have gaskets or seals to provide a positive seal against air leakage. A manometer shall be installed across each filter bed having a required efficiency of 75 percent or more, including hoods requiring HEPA filters. Reservoir-type sprays shall not be used.

viii. Air-handling duct systems shall meet the requirements of NFPA 90A and those contained herein.

ix. Ducts that penetrate construction intended for X-ray or other ray protection shall not impair the effectiveness of the protection.

x. Fire and smoke dampers shall be constructed, located, and installed in accordance with the requirements of NFPA 101 and 90A. Fans, dampers, and detectors shall be interconnected so that damper activation will not damage the ducts. Maintenance access shall be provided at all dampers. All damper locations shall be shown on drawings. Dampers should be activated by fire or smoke sensors, not by fan cutoff alone. Switching systems for restarting fans may be installed for fire department use in venting smoke after a fire has been controlled. However, provisions should be made to avoid possible damage to the system due to closed dampers. When smoke partitions are required, heating, ventilating, and air conditioning zones shall be coordinated with compartmentation insofar as practical to minimize need to penetrate fire smoke partitions.

xi. If air change standards in table 3 do not provide sufficient air for use by hoods and safety cabinets, makeup air shall be provided to maintain the required airflow direction and to avoid dependence upon infiltration from outdoor or contaminated areas.

xii. Laboratory hoods shall have an average face-velocity of at least 75 feet per minute (0.38 meters per second). They shall be connected to an outside-vented exhaust system separate from the building exhaust system and have an exhaust fan located at the discharge end. In addition, they shall have an exhaust duct system made of noncombustible corrosion-resistant material designed to accommodate the planned usage of the hood.

xiii. Laboratory hoods used to process infectious or radioactive materials shall meet special standards. In new construction and major renovation work, each hood used to process infectious or radioactive materials shall have a minimum face-velocity of 150

Table 8
Filter Efficiencies for Central Ventilation and Air Conditioning Systems in Outpatient Facilities

Area designation	**No. filter beds**	**Filter efficiencies (%)**	
		Filter bed no. 1	**Filter bed no. 2**
Critical areas*	2	25	90
All noncritical areas for patient care, treatment, and/or diagnosis, and those areas providing direct or support services such as clean supplies, laboratories, sterile and clean processing, bulk storage, soiled holding areas, administrative	1	25	—

Note: Additional roughing or prefilters should be considered to reduce maintenance required for main filters. Ratings shall be based on ASHRAE 52–76.

*Operating rooms.

feet per minute with suitable static-pressure-operated dampers and alarms to alert staff of fan shutdown. Each shall also have filters with a 99.97 percent efficiency (based on the DOP, dioctyl-phthalate test method) in the exhaust stream, and be designed and equipped to permit the safe removal, disposal, and replacement of contaminated filters. Filters shall be as close to the hood as practical to minimize duct contamination. Hoods that process radioactive materials shall meet requirements of the Nuclear Regulatory Commission. (Note: Radioactive isotopes used for injections, etc., without probability of airborne particulates or gases might be processed in a clean workbench-type hood in keeping with standards acceptable to the Nuclear Regulatory Commission.) Ducts serving hoods for radioactive material shall be constructed of acid-resistant stainless steel overall and have a minimum number of joints. Duct systems serving hoods in which strong oxidizing agents (e.g., perchloric acid) are used shall be constructed of acid-resistant stainless steel for at least 10 feet (3.05 meters) from the hood and shall be equipped with washdown facilities. Provisions shall be made for safe removal of filters during washdown operations.

xiv. The ventilation system for anesthesia storage rooms shall conform to the requirements of NFPA 99.

xv. Where ethylene oxide is used for sterilization, provisions shall be made for complete exhaust of gases to the exterior. Provisions shall be made to insure that when the sterilizer door is open, gases are pulled away from the operator. Provisions shall also be made for appropriate aeration of supplies. Aeration cabinets shall be vented to the outside. Where aeration cabinets are not used in ethylene oxide processing, an isolated area for mechanically venting gases to the outside shall be provided.

xvi. Boiler rooms shall be provided with sufficient outdoor airflow to maintain equipment combustion rates and to limit workstation temperatures.

xvii. Gravity exhaust may be used, conditions permitting, for nonpatient areas such as boiler rooms, central storage, etc.

xviii. The energy-saving potential of variable-air-volume systems is recognized, and the standards herein are intended to maximize appropriate use of such systems. Any ventilation system used for occupied areas must include provisions to avoid air stagnation in interior spaces where thermostat demands are met by temperatures of surrounding areas.

M. Plumbing and Other Piping Systems

All plumbing systems shall be designed and installed in accordance with the *National Standard Plumbing Code*, chapter 14, "Medical Care Facility Plumbing Equipment."

1. The following standards shall apply to plumbing fixtures:

a. The material used for plumbing fixtures shall be nonabsorptive and acid-resistant.

b. Handwashing facilities for staff in patient care areas shall be trimmed with valves that can be operated without hands (single-lever devices may be used, subject to above). Where blade handles are used, they shall not exceed 4½ inches (11.4 centimeters) in length, except that handles on clinical sinks shall be not less than 6 inches (15.2 centimeters) long.

2. The following standards shall apply to water systems:

a. Systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand.

b. Each water service main, branch main, riser, and branch to a group of fixtures shall have valves. Stop valves shall be provided at each fixture.

c. Backflow preventers (vacuum breakers) shall be installed on fixtures to which hoses or tubing can be attached.

3. The following standards shall apply to drainage systems: Building sewers shall discharge into a community sewage system. Where such a system is not available, sewage treatment must conform to applicable local and state regulations.

4. All piping in the HVAC and service-water systems shall be color coded or otherwise marked for easy identification.

N. Electrical Standards

1. All material and equipment, including conductors, controls, and signaling devices, shall be installed to provide a complete electrical system with the necessary characteristics and capacity to supply the electrical systems as indicated on plans and in the functional program. All materials shall be listed as complying with available standards of Underwriters' Laboratories, Inc., or other similar established standards. All electrical installations and systems shall be tested to show that the equipment operates in accordance with design intent. Installation shall be in accordance with applicable sections of NFPA 70.

2. Circuit breakers or fused switches that provide electrical disconnection and overcurrent protection for switchboard and panelboard conductors shall be enclosed or guarded to provide a dead-front assembly. The main switchboard shall be readily accessible for use and maintenance, set apart from traffic lanes, and located in a dry, ventilated space, free of corrosive fumes or gases. Overload protective devices shall operate properly in ambient temperature conditions.

3. Panelboards serving lighting and appliance circuits shall be on the same floor and in the same facility area as the circuits they serve.

4. The following standards for lighting shall apply:

a. All spaces occupied by people, machinery, or equipment within buildings, approaches to buildings, and parking lots shall have lighting.

b. A portable or fixed examination light shall be provided for examination, treatment, and trauma rooms.

5. Duplex grounded-type receptacles (convenience outlets) shall be installed in all areas in sufficient quantities for tasks to be performed as needed. Each examination and work table shall have access to a minimum of two duplex receptacles.

6. Automatic emergency lighting shall be provided for safe egress from the building in the event of power failure in accordance with NFPA 99.

7. A manually operated, electrically supervised fire alarm system shall be installed in each facility that has a total floor area of more than 6,000 square feet (557 square meters). The fire alarm system shall be as described in NFPA 101.

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC

STANDARDS MANUAL

for accreditation of ambulatory plastic surgery facilities

AAAPSF

AMERICAN ASSOCIATION FOR ACCREDITATION OF
AMBULATORY PLASTIC SURGERY FACILITIES, INC.

AAAAPSF ACCREDITATION OFFICE
1202 Allanson Rd./Mundelein, Illinois 60060
(312) 949-6056

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Revised, 1987, 1989

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FOREWORD

This document, containing voluntary standards for plastic surgery facilities, was prepared by the Standards Committee of the AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC. (AAAAPSF), and adopted by its Board of Directors in February 1981, and revised by the Board of Directors in April 1987.

These voluntary standards, the checklist/questionaire, and the on-site peer inspection are intended to be educational to insure and maintain superior care for the plastic surgery patient.

Revised
May, 1989

DEFINITIONS

1. Plastic Surgical Facility:

   An establishment with permanent facilities within an ABPS certified plastic surgeon's office or under his direction that is equipped and operated primarily for the purpose of performing plastic surgical procedures. The following services will be available while a patient is in the facility;

   a) All medications and equipment needed for operations performed.

   b) Provisions for physical and emotional well-being of patients and relatives.

   c) Provision of services for emergencies which may arise in the facility.

   d) Efficient storage and retrieval of administrative, statistical and medical records.

   e) Provisions for laundry service as needed.

2. Plastic Surgeon:

   A person who holds a valid license to practice medicine and surgery issued by his or her state and is certified by the American Board of Plastic Surgery.

3. Patient:

   A person admitted to the surgical facility by and upon the order of a physician.

4. Operating Room Personnel:

   a) Registered Nurse (R.N.) - A person who holds a valid license issued by that state's Board of Nursing to practice nursing as defined in that state's statutes.

   b) Licensed Practical Nurse (LPN) - A person who holds a valid license issued by that state's Board of Nursing to practice practical nursing as defined in that state's statutes.

   c) Licensed Vocational Nurse (LVN) - A person who holds a valid license issued by that state's Board of Nursing to practice vocational nursing as defined by that state's statutes.

DEFINITIONS—continued

4. Operating Room Personnel: (cont'd)

    d) Graduate Nurse - Not yet licensed, but a graduate of an approved nursing program.

    e) Certified Operating Room Technician - A person certified by a recognized (O.R.T.) state certifying board.

    f) Plastic Surgical Technician - A person trained by an individual plastic surgeon to assist at surgery.

5. Anesthesia Personnel:

    a) Anesthesiologist - a physician trained in anesthesia either board certified or eligible.

    b) C.R.N.A. - a certified registered nurse anesthethist licensed in the state in which he/she is practicing.

ACCREDITATION GUIDELINES

1. Plastic surgical facilities will be accredited on a voluntary basis.

2. Accreditation shall be issued for a period of not less than three years for all new applicants and renewals.

3. The cost of accreditation shall be borne by the facility inspected.

4. The voluntary inspection may be conducted by a member of a panel designated by the governing body. The facility may veto up to three members of the panel.

5. The inspector will forward a report of the inspection to the executive office of the governing body for review and evaluation by the proper committee. A copy will simultaneously be sent to the inspected facility. The inspected facility, if found delinquent, may request a reinspection. Such request will be evaluated by the Board of Directors as quickly as feasible and a decision made to accept or reject the request.

GENERAL STANDARDS AND FACILITY CLASSIFICATIONS

The standards for accreditation are categorized as follows:

I. PATIENT CARE

II. FACILITY

III. SAFETY

IV. PERSONNEL

V. QUALITY ASSURANCE

VI. ADMINISTRATIVE DOCUMENTATION

Plastic surgical facilities are classified as follows:

Class A:

Performed under local, regional, or topical anesthesia; applies to minor plastic surgical procedures.

Class B:

Performed under intravenous or parenteral sedation, analgesia or dissociative drugs; applies to minor or major plastic surgical procedures.

**Class C:*

Major plastic surgery procedures performed under general anesthesia with external support of vital body functions.

Plastic surgical facilities will be accredited according to the following classifications:

Class A	(Only)
Class A,B	(Cumulative)
Class A,B,C	(Cumulative)

---

*These facilities are not accredited for elective surgery in major body cavities.

GENERAL STANDARDS AND FACILITY CLASSIFICATIONS—continued

I. **PATIENT CARE:** The facility shall maintain an appropriate environment to provide acceptable quality medical care.

		FACILITY CLASSIFICATION
1.	An appropriate history, physical examination, and laboratory examination should be completed prior to surgery. The lab requirements in a class A facility will be left to the surgeons judgment.	A,B,C
2.	Clinical laboratory services for appropriate clinical and hematological procedures shall be available	A,B,C
3.	Admissions of patients, personnel and visitors shall be controlled.	A,B,C
4.	All anesthetics shall be given by a physician or shall be administered under the supervision of a physician.	A,B,C
5.	Resuscitation and suction equipment shall be available at all times. Monitoring equipment shall be also available.	B,C
6.	The facility must have the capability of obtaining blood or blood substitute.	A,B,C
7.	Suitable drugs for cardiopulmonary resuscitation will be available and should be consistent with acceptable current standards.	B,C
8.	Appropriate supervision should be maintained during the period of patient recovery. Electronic means may be employed.	B,C

best copy available

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GENERAL STANDARDS AND FACILITY CLASSIFICATIONS—continued

II. FACILITY: The facility shall be physically adequate for the performance of procedures for which it is accredited. A patient's bill of rights should be posted where it may be easily seen by patients or someone responsible to the patient.

	SEE APPENDIX A	FACILITY CLASSIFICATION
1.	There shall be a minimum of at least one operating room that is used exclusively for surgery and at least one post-surgery recovery room or designated area.	B,C
2.	Adequate space, equipment, and personnel shall be provided to assist in the safe and aseptic treatment and protection of all surgical patients, including reasonable protection against cross-infection.	A,B,C
3.	Suitable surgical lighting will be provided with an appropriate emergency lighting source available in the event of power failure.	A,B,C
4.	A suitable operating table or stretcher must be provided which has full capabilities for the performance of all scheduled cases.	B,C
5.	All equipment for the administration of anesthetics shall be readily available, kept clean, and properly maintained.	A,B,C
6.	(a) Suitable resuscitation equipment consisting of airways, endotracheal or esophageal tubes with laryngoscope and oxygen sources with positive pressure capabilities will be provided.	B,C
	(b) Oral airways and bag-mask respirator shall be available.	A
7.	Suction equipment for operating and recovery areas will be available at all times.	B,C
8.	Conductive flooring and conductive moveable equipment shall be required in operating rooms where flammable and explosive anesthetics are used.	A,B,C
9.	There shall be adequate hand-washing facilities, conveniently located.	A,B,C
10.	A sufficient supply of cloth or disposable towels should be available so that a fresh towel can be used after each hand-washing. Common towels are prohibited.	A,B,C

GENERAL STANDARDS AND FACILITY CLASSIFICATIONS—continued

II. FACILITY: (continued)

		FACILITY CLASSIFICATION
11.	All openings to the outer air shall effectively protect against the entrance of insects or animals by self-closing doors, closed windows, screening, controlled air current, or other effective means.	A,B,C
12.	Suitable equipment or service shall be provided for the regular cleaning of all interior surfaces.	A,B,C
13.	The premises shall be kept neat, clean, and free of waste material.	A,B,C
14.	The plastic surgical facility shall have a plan for transferring emergency cases requiring unusual care.	B,C
15.	Procedures which require the presence of unusual equipment, personnel, and/or facilities shall be performed inthe plastic surgical facilities where such equipment, personnel and/or facilities are available.	A,B,C
16.	Appropriate monitoring equipment consistent with accepted plastic surgical standards should be available; for example:	
	(a) Blood pressure apparatus	A,B,C
	(b) EKG oscilloscope; when this type of monitoring is used, a defibrillator shall be available	B,C
	(c) Pulse oximeter with alarm	B,C
	(d) O_2 (oxygen) analyzer	B,C
17.	Intravenous fluids and appropriate administration equipment should be available.	B,C
18.	Appropriate and readily available conveyances such as wheelchairs and/or stretcher carts shall be provided.	B,C
19.	Dressing and lounge areas for personnel and patients shall be provided in such a manner as not to jeopardize the safe treatment of surgical patients.	B,C
20.	An adequate waiting area shall be provided for patients, relatives, and/or escorts.	A,B,C
21.	Appropriate business office facilities shall be provided.	A,B,C

GENERAL STANDARDS AND FACILITY CLASSIFICATIONS—continued

III. SAFETY: The facility shall maintain adequate safety measures that shall meet all prevailing local, state, and federal codes appropriate for the protection of the patient and personnel within such a facility.

		FACILITY CLASSIFICATION
1.	There shall be compliance with all applicable local and state fire, safety, sanitation, and building codes for physicians' offices.	A,B,C
2.	All garbage and waste shall be collected, stored, and disposed of in a manner designed to prevent the transmission of disease.	A,B,C
3.	Common drinking cups shall be prohibited.	A,B,C
4.	Dry sweeping and dusting shall be prohibited.	A,B,C
5.	Appropriate means of control against hazards of electrical or mechanical failures shall be provided.	A,B,C
6.	Periodic drills shall be held to prepare employees for emergencies.	B,C
7.	The facility shall have plans for emergencies.	A,B,C
8.	Smoking shall be prohibited in the surgical suites.	A,B,C
9.	Combustible materials and supplies shall be stored and handled in a safe and approved manner, and in conformance with applicable codes and regulations.	A,B,C
10.	Volatile supplies shall be stored and kept in a safe manner. For medications provided, there shall be proper storage, safe-guarding, preparation and dispensing.	A,B,C
11.	Fire extinguishers shall be of types and makes that are approved by Underwriters Laboratories. Extinguishers shall be inspected and tagged routinely.	A,B,C
12.	Appropriate safety measures should be implemented when using electrocautery.	A,B,C
13.	The plastic surgeon and his operating room personnel shall be trained in cardio-pulmonary resuscitation.	B,C

GENERAL STANDARDS AND FACILITY CLASSIFICATIONS—continued

IV. PERSONNEL: The facility shall be under the direction of a licensed physician who is certified by the American Board of Plastic Surgery. The other personnel shall meet acceptable standards as defined by their professional governing bodies, where applicable.

		FACILITY CLASSIFICATION
1.	There should be an individual who will delineate the areas of responsibility and duties of each category of nursing personnel. This person will be in charge of the entire operation with full responsibility for all equipment, critical supplies, personnel assignments, and duties.	A,B,C
2.	All registered nurses practicing in the plastic surgical facilities shall be licensed in their respective states.	A,B,C
3.	All practical nurses practicing in the plastic surgical facilities shall be licensed in their respective states.	A,B,C
4.	All vocational nurses practicing in the plastic surgical facilities shall be licensed in their respective states.	A,B,C
5.	All graduate nurses practicing in the plastic surgical facilities shall have graduated from an approved nursing program.	A,B,C
6.	All certified operating room technicians practicing in the plastic surgical facilities shall be certified by a recognized (O.R.T.) state certifying board.	A,B,C
7.	All plastic surgical technicians practicing in the plastic surgical facilities shall be thoroughly trained in aseptic operating techniques and their training personally approved by or supervised by a qualified plastic surgeon.	A,B,C
8.	The circulating nurse and the recovery room nurse shall be a Professional Registered Nurse (R.N.).	A,B,C

GENERAL STANDARDS AND FACILITY CLASSIFICATIONS—continued

V. QUALITY ASSURANCE: **The quality assurance within the facility shall be sufficient to provide the appropriate performance of the plastic surgical procedures.**

		FACILITY CLASSIFICATION
1.	Currently acceptable procedures to minimize sources and transmissions of infections shall be employed. Adequate surveillance methods shall be used.	A,B,C
2.	A satisfactory description of the findings and technique of operation shall be made as part of the patient's permanent records.	A,B,C
3.	Tissues removed at surgery shall be examined by a pathologist where appropriate. The report shall be made a part of the patient's office record.	A,B,C
4.	Sterile supplies and equipment shall not be mixed with unsterile supplies. All items shall be appropriately labeled.	A,B,C
5.	Appropriate sterilizers and autoclaves shall be provided to adequately and safely perform their intended function. The accuracy of instruments shall be checked periodically by an approved method. Adequate surveillance for checking sterilization procedures shall be employed.	A,B,C
6.	The date of sterilization or date of expiration shall be marked on all "in-house" sterile supplies.	A,B,C
7.	Group practise plastic surgeons shall periodically review random cases and cases with complications at the least, quarterly. These meetings shall be properly documented.	A,B,C
8.	For solo practitioners with a plastic surgical facility, it is suggested that a review committee be formed with members of the plastic surgeons section of the medical staff of the hospital at which he/she holds admitting privileges for the purpose of periodically reviewing random cases or cases with complications. If this is not feasible, some similar organizations of local plastic surgeons be established for the purpose of peer review. These meetings shall be properly documented.	A,B,C

GENERAL STANDARDS AND FACILITY CLASSIFICATIONS—continued

VI. ADMINISTRATIVE DOCUMENTATION: There shall be an appropriate administrative structure to provide for the documentation, storage, and retrieval of all necessary patient information. In addition, provisions shall be made for all supportive services necessary for the operation of the facility.

	FACILITY CLASSIFICATION
1. Patient's undergoing surgery will have, as a part of routine:	
(a) Medical records: a specific individual be designated as administrator to supervise and/ or maintain all record keeping functions.	
(1) Appropriate medical history and physical examination	A,B,C
(2) Operative notes or report	A,B,C
(3) Progress notes	A,B,C
(4) A complete record of medications	A,B,C
(b) Consent Forms	A,B,C
(c) Pathologist Report (where applicable)	A,B,C
(d) Laboratory Determinations (as indicated)	A,B,C
2. Medical records are the property of the operating surgeon and his associates. Only authorized personnel shall have access to the records.	A,B,C
3. Medical records should be maintained in retrievable form according to the applicable maximum limit of Statute of Limitations in the state where the surgery is performed.	A,B,C
4. Policies and procedures shall be established for storage, maintenance, and distribution of supplies and equipment.	A,B,C
5. Provisions shall be made for the proper laundering of linen and washable goods. Soiled and cleaned linen will be handled and sorted separately.	A,B,C

SUGGESTED FACILITY REQUIREMENTS FOR PLASTIC SURGERY OPERATING ROOMS

I. SUGGESTED EQUIPMENT:

		FACILITY CLASSIFICATION
1.	Surgical Lights: type optional	A,B,C
2.	Emergency lighting source (stationary or hand-held battery operated or emergency power source)	A,B,C
3.	Fire extinguisher	A,B,C
4.	Suitable resuscitation equipment to include:	
	(a) maintenance of airway	A,B,C
	(b) suitable drugs	B,C
	(c) O_2; with appropriate positive pressure apparatus attachable to O_2 source	B,C
	(d) Bag-mask plus oral airway	A
5.	Suction equipment; type optional available to operating room and/or recovery area	B,C
6.	Operating table or stretcher, instrument trays, electrocautery	B,C
7.	Recovery area; signal, monitoring, or observation methods	B,C
8.	Adequate sterilization equipment; type optional	A,B,C
9.	Blood pressure equipment; routine for operating room and recovery area	A,B,C
10.	Monitoring equipment, for example:	
	(a) automated blood pressure monitor	B,C
	(b) Cardiac monitor with defibrillator	B,C
11.	Equipment for IV fluids, etc.	B,C
12.	Ancillary equipment such as kick buckets, Mayo stands, back tables, waste cans, etc.	B,C
13.	**Anesthesia machine**	A,B,C
	a) with O_2 Monitor	A,B,C
	b) with purge system	A,B,C

SUGGESTED FACILITY REQUIREMENTS FOR PLASTIC SURGERY OPERATING ROOMS
—continued

	FACILITY CLASSIFICATION
II. PERSONNEL:	
1. One registered nurse or paramedical personnel (thoroughly indoctrinated) to be in charge of the entire operation with full responsibility for all equipment, critical supplies, personnel assignments and duties.	A,B,C
III. MEDICAL RECORDS:	
1. Routine office records and special notations where applicable; should include:	
(a) operative notes or report	A,B,C
(b) progress notes	A,B,C
(c) record of medications, dosages, times administered, and response	A,B,C
2. Consent forms	A,B,C
3. Microscopic report; where applicable	A,B,C
4. Laboratory work-up; as indicated	A,B,C

A PATIENT'S BILL OF RIGHTS

The (NAME OF FACILITY) presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the group organization. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.

3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity, (NAME OF FACILITY) must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8. The patient has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.

9. The patient has the right to be advised if the (NAME OF FACILITY) proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

10. The patient has the right to expect reasonable continuity of care. He has the right to kow in advance what appointment times and physicians are available and where. The patient has the right to expect that this facility will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

12. The patient has the right to know what our facility rules and regulations apply to his conduct as a patient.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. This facility has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

PATIENT RESPONSIBILITIES

It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur.

The patient is expected to follow up on his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels is necessary.

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC.

CHECKLIST/QUESTIONNAIRE

for accreditation of ambulatory plastic surgery facilities

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC

CHECKLIST/QUESTIONNAIRE

for accreditation of ambulatory plastic surgery facilities

AAAAPSF

AMERICAN ASSOCIATION FOR ACCREDITATION OF
AMBULATORY PLASTIC SURGERY FACILITIES, INC.

AAAAPSF ACCREDITATION OFFICE
1202 Allanson Rd./Mundelein, Illinois 60060
(312) 949-6058

PREFACE

The Questionnaire/Checklist is designed to assist the applicant of the Voluntary Accreditation Program in preparing the facility to meet AAAAPSF Standards. It is also designed to support the volunteer inspector in a complete and objective evaluation of an Ambulatory Surgery Facility.

In Sections II through VII, the questions are classified according to the definitions listed in the Standards Manual as follows:

CLASS A - Performed under local, regional, or topical anesthesia; applies to minor plastic surgical procedures.

CLASS B - Performed under intravenous or parenteral sedation, analgesia or dissociative drugs; applies to minor or major plastic surgical procedures.

CLASS C - Major plastic surgery procedures performed under general anesthesia with external support of vital body functions.

CLASS I - Questions classified as "I" are for information only and will not be evaluated to determine the accreditation status of the facility.

For the Applicant

Please complete Sections I and II prior to returning the Questionnaire/Checklist to the Accreditation Office. These sections are informational and are required to assist AAAAPSF and the inspector in preparing for on site inspection and facility classification. The information requested in Sections I and II will have no bearing on the final accreditation of your facility.

Use the remaining Sections of the Checklist to self-evaluate your facility prior to the on site inspection.

For the Inspector

Prior to the inspection, please familiarize yourself with the Standards Manual, the inspector's Manual, and the Questionnaire/Checklist. When reviewing the Questionnaire/Checklist, the applicant completed Sections I and II should provide you with a preview of the facility to be inspected.

The questionnaire will provide guidelines for the objective evaluation of the facility. Each question in the checklist must be answered.

Any comments or suggestions for improving the Questionnaire/Checklist should be addressed to the Accreditation Office for review by the appropriate committee of the Association.

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Ambulatory Plastic Surgery Facilities, Inc. – 1981
Revised, 1987, 1989

AMERICAN ASSOCIATION FOR ACCREDITATION
OF AMBULATORY PLASTIC SURGERY FACILITIES

INSPECTION QUESTIONNAIRE & CHECKLIST

SECTION I

GENERAL INFORMATION QUESTIONNAIRE

PLEASE PRINT OR TYPE

FOR THE APPLICANT

This section of the Questionnaire/Checklist is to be completed by the applicant. The questions are information only for the inspector preparation and will not be used in the evaluation of the facility.

Facility I. D. No. ___ - ___ - __ **(Assigned by Accreditation Office)**

Name of Director____

Name of Facility____

Address____

____

City________________________State__________________Zip__________

Phone _ _ _ _ _ _ _ _ _ _

Name of Inspector____
(Assigned by Association)

Name (s) of Facility Owner, Controlling Stockholder and/or Beneficial Ownership.

____

____

____

____
(Additional names on separate sheet)

Date of Inspection ____

*Hospital Affiliation (Staff Privileges)______________________________

____

____

ACCREDITATION HISTORY

( ) Not Previously Accredited   ( ) Previously Accredited

Initial Inspection Date ____________

Reinspection Date____________

Other Accreditation________________Facility Licensure________________

Staff

List the names of the Board Certified Plastic Surgeons using this facility.

Approximate
% of Practice

1.)______________________________ ( )( )( )

2.)______________________________ ( )( )( )

3.)______________________________ ( )( )( )

4.)______________________________ ( )( )( )

5.)______________________________ ( )( )( )

(Provide additional names on separate paper if more than 5)

Other Physician Staff

Number of Residents in this Facility ( )( )

Number of Post Graduate Fellows ( )( )

Other, Describe____________________ ( )( )

* There shall be no accreditation without all physician staff members having an affiliation in a duly accredited hospital in the community in the specialty of Plastic Surgery.

Nursing Staff

Number of R.N.'s ( )( )

Number of L.P.N.'s ( )( )

Number of L.V.N.'s ( )( )

Number of Physician Trained Technicians ( )( )

Other, Indicate_________________________ ( )( )

If no R.N. is on the Staff, indicate the name and education of

Supervisor_______________ _____

Administrative Staff

Number of Secretarial/Clerical Personnel ( )( )

Other, Indicate_________________________

FACILITY

Please enclose a sketch of the floor plan of the facility indicating room size, function and general arrangement.

	Indicate Approximate Square Footage
Waiting Area	( )( )( )( ) Sq.Ft.
Administrative and Secretarial Area	( )( )( )( ) Sq.Ft.
Physician Office(s)	( )( )( )( ) Sq.Ft.
Number	( )( )
Examination Room(s)	( )( )( )( ) Sq.Ft.
Number	( )( )
Operating Room(s)	( )( )( )( ) Sq.Ft.
Number	( )( )
Recovery Area(s)	( )( )( )( ) Sq.Ft.
Number	( )( )
Storage Area(s)	( )( )( )( ) Sq.Ft.
Other, Specify________________________________	( )( )( )( ) Sq.Ft.
Total Facility	( )( )( )( )( )

Number of Procedures Performed per year in the Facility (approximate).

Range of number of procedures performed: (RANGES — (1) 1-10 • (2) 11-50 • (3) 51-100 • (4) 101 or more)	**Range Number Indicate**
Minor Skin Procedures	( )
Blepharoplasty	( )
Rhinoplasty	( )
Otoplasty	( )
Rhytidectomy	( )
Chemical peels	( )
Dermabrasion	( )
Hair Transplants	( )
Breast Surgery	( )
Abdominal Lipectomy	( )
Body Sculpturing	( )
Hand Surgery	( )
Maxillofacial	( )
Cleft	( )
Other, Describe________________________________	( )

Equipment/Instruments

Please list all major equipment by the category indicated. If space is not sufficient, please list and include on a separate piece of paper.

Beds/Gurneys	**Make/Model**	**Number**
1.)______________________	______________	( )( )
2.)______________________	______________	( )( )
3.)______________________	______________	( )( )
4.)______________________	______________	( )( )
5.)______________________	______________	( )( )

Operating Tables, Chairs
Tables/Chairs **Make/Model** **Number**

1.)____ ( )( )
2.)____ ( )( )
3.)____ ( )( )
4.)____ ( )( )
5.)____ ( )( )

Operating Room lights and
Emergency Lighting Equipment **Make/Model** **Number**

1.)____ ( )( )
2.)____ ( )( )
3.)____ ( )( )
4.)____ ( )( )
5.)____ ( )( )

Emergency power source — e.g. Generator, Battery Medical, etc., Type, Model, Capacity (KV).

1.)____ ( )( )
2.)____ ( )( )
3.)____ ( )( )
4.)____ ( )( )
5.)____ ( )( )

EQUIPMENT

List Major equipment such as electrosurgical units, autoclaves, cardiac monitors, gas sterilizers, blood pressure monitors, and defibrillators. Anesthesia machines, suction equipment, Fiberoptic equipment, emergency equipment.

Instrument **Make/Model** **Number**

1.)______________________________ ( )( )
2.)______________________________ ( )( )
3.)______________________________ ( )( )
4.)______________________________ ( )( )
5.)______________________________ ( )( )
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22.)______________________________ ( )( )
23.)______________________________ ( )( )
24.)______________________________ ( )( )
25.)______________________________ ( )( )

SECTION II

To Be Completed By The Participant

PROCEDURES PERFORMED:

		*CLASS		
001.00.0	Minor Skin Procedures.		YES	NO
001.01.0	Excisions of skin lesions.	A	YES	NO
001.02.0.	Excisions of tatoos.	A	YES	NO
001.03.0	Excisions and revision of scars.	A	YES	NO
002.00.0	Blepharoplasty.		YES	NO
002.01.0	Upper eyelids only.	B	YES	NO
002.02.0	All four eyelids.	B	YES	NO
002.03.0	All four eyelids and fat herniations when present.	B	YES	NO
003.00.0	Rhinoplasty as an office procedure.		YES	NO
003.01.0	A complete rhinoplasty.	B	YES	NO
003.02.0	Tip rhinoplasty.	B	YES	NO
003.03.0	Repair of deviated nasal septum.	B	YES	NO
004.00.0	Otoplasty.		YES	NO
004.01.0	On adults.	B	YES	NO
004.02.0	On children.	B	YES	NO
005.00.0	Rhytidectomy as an office procedure.		YES	NO
005.01.0	Complete.	B	YES	NO
005.02.0	Regional only.	B	YES	NO
006.00.0	Chemical peel.		YES	NO
006.01.0	Total.	B	YES	NO
006.02.0	Regional only.	A	YES	NO

*The class in the minimum facility category in which the procedures may be performed.

		*CLASS	
007.00.0	Dermabrasion.		YES NO
007.01.0	Regional only.	A	YES NO
007.02.0	Total face.	B	YES NO
008.00.0	Face Surgery.		YES NO
008.01.0	Insertion of Exogenous materials - Injectable.	A	YES NO
008.02.0	Insertion of Exogenous materials - Solid.		YES NO
008.02.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
008.02.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
009.00.0	Hair transplants.		YES NO
009.01.0	Punches or plugs.	A	YES NO
009.02.0	Hair strips.	A	YES NO
009.03.0	Rotation flaps.	B	YES NO
010.00.0	Breast surgery in the office.		YES NO
010.01.0	Biopsy.		YES NO
010.01.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
010.01.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
010.02.0	Mastopexy.		YES NO
010.02.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
010.02.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO

*The class in the minimum facility category in which the procedures may be performed.

		*CLASS	
010.03.0	Augmentation Mammoplasty.		YES NO
010.03.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
010.03.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
010.04.0	Reduction mammoplasty.		YES NO
010.04.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
010.04.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
010.05.0	Subcutaneous mastectomy - limited.		YES NO
010.05.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
010.05.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
010.06.0	Subcutaneous mastectomy - complete.		YES NO
010.06.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
010.06.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
011.00.0	Abdominal lipectomy.		YES NO
011.01.0	Major.		YES NO
011.01.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
011.01.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
011.02.0	Minor.		YES NO
011.02.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO

*The class in the minimum facility category in which the procedures may be performed.

		†CLASS	
011.02.2	With use of general anesthesia and support of functions such as blood pressure, blood volume and respiration.	C	YES NO
012.00.0	Other body sculpturing procedures.		YES NO
012.01.0	Arms.		YES NO
012.01.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
012.01.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
012.02.0	Thighs.		YES NO
012.02.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
012.02.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
012.03.0	Buttocks.		YES NO
012.03.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
012.03.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.00.0	Hand Surgery.		YES NO
013.01.0	Lesions.	A	YES NO
013.02.0	Scar Contractures.	A	YES NO
013.03.0	Nail (or matrix) revision.	A	YES NO
013.04.0	Surgery of the bones of the hand.		YES NO
013.04.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.04.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.05.0	Closed reduction of fractures.		YES NO
013.05.1	With use of local anesthesia only.	A	YES NO

†The class in the minimum facility category in which the procedures may be performed

		*CLASS	
013.05.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.05.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.06.0	Open reduction of fractures.		YES NO
013.06.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.06.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.07.0	Major bone revisions or osteotomies.		YES NO
013.07.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.07.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.08.0	Minor bone revisions or osteotomies.		YES NO
013.08.1	With use of local anesthesia with intravenous, hypnotic, tranquilizers and/or dissociative agents.	B	YES NO
013.08.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.09.0	Reconstruction or repair of ligamentous joint structures.		YES NO
013.09.1	With use of local anethesia with intravenous, hypnotic, tranquilizers and/or dissociative agents.	B	YES NO
013.09.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.10.0	Arthroplasty with prosthesis.		YES NO
013.10.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO

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*The class in the minimum facility category in which the procedures may be performed.

		*CLASS	
013.10.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.11.0	Skin grafts.		YES NO
013.11.1	With use local anesthesia only.	A	YES NO
013.11.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.11.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.12.0	Tendons.		YES NO
013.12.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.12.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.13.0	Extensor tendon repair.		YES NO
013.13.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.13.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.14.0	Flexor tendon repair.		YES NO
013.14.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.14.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.15.0	Digital nerve repair.		YES NO
013.15.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO

*The class in the minimum facility category in which the procedures may be performed.

		*CLASS	
013.15.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.16.0	Prosthesis for hand surgery.		YES NO
013.16.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.16.2	With use of general anesthesia and support of vital functions such as blood-pressure, blood volume and respiration.	C	YES NO
013.17.0	M.P. or P.I.P. joints.		YES NO
013.17.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.17.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.18.0	Tendon or rod spacers.		YES NO
013.18.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.18.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.19.0	Carpal Prothesis.		YES NO
013.19.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.19.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
013.20.0	Dupuytrens contractures.		YES NO
013.20.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.20.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO

*The class in the minimum facility category in which the procedures may be performed

		*CLASS	
013.21.0	Microvascular anastomosis.		YES NO
013.21.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
013.21.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.00.0	Maxillofacial surgery.		YES NO
014.00.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.00.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.01.0	Nasal fracture.		YES NO
014.01.1	With use of local anesthesia only.	A	YES NO
014.02.0	Open reduction.		YES NO
014.02.1	With use of local anesthesia only.	A	YES NO
014.02.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.02.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.03.0	Closed reduction.		YES NO
014.03.1	With use of local anesthesia only.	A	YES NO
014.03.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.03.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.04.0	LaForte I fractures		YES NO
014.04.1	With use of local anesthesia only.	A	YES NO
014.04.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO

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*The class in the minimum facility category in which the procedures may be performed.

		*CLASS	
014.04.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.05.0	LaForte II	C	YES NO
014.06.0	Zygomatic Arch Fracture.		YES NO
014.06.1	With use of local anesthesia only.	A	YES NO
014.06.2	With use of local anethesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.06.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.07.0	Orbital rim fractures.		YES NO
014.07.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.07.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.08.0	Blow-out or orbital floor fractures.		YES NO
014.08.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.08.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.09.0	Tripod Trimalar Fractures.		YES NO
014.09.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.09.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.10.0	Mandibular fractures.		YES NO
014.10.1	With use of local anesthesia only.	A	YES NO
014.10.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO

*The class in the minimum facility category in which the procedures may be performed.

		*CLASS	
014.10.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.11.0	Application of intraoral fixation appliances.		YES NO
014.11.1	With use of local anesthesia only.	A	YES NO
014.11.2	With use of local anesthesia and intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.11.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.12.0	Removal of intraoral fixation appliances.		YES NO
014.12.1	With use of local anesthesia only.	A	YES NO
014.12.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.12.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.13.0	Cleft lip, primary, adult.		YES NO
014.13.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.13.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.14.0	Cleft lip, primary, infant.	C	YES NO
014.15.0	Secondary cleft lip (or nose) deformities.		YES NO
014.15.1	With use of local anesthesia only.	A	YES NO
014.15.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
014.15.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
014.16.0	Cleft palate, primary.	C	YES NO
014.17.0	Secondary cleft palate and/or related problems.	C	YES NO

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*The class in the minimum facility category in which the procedures may be performed

		*CLASS	
015.00.0	Urological Surgery.		YES NO
015.01.0	Meatotomy, Adult.	A	YES NO
015.02.0	Meatotomy, Child.		YES NO
015.02.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
015.02.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
015.03.0	Primary Hypospadias.		YES NO
015.03.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
015.03.2	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
015.04.0	Secondary Hypospadias Repairs.		YES NO
015.04.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
015.04.2	With use of general anesthesia and support of vital functions, such as blood pressure, blood volume and respiration.	C	YES NO
015.05.0	Penile Implant.		YES NO
015.05.1	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
015.05.2	With use of general anesthesia and support of vital functions, such as blood pressure, blood volume and respiration.	C	YES NO
015.06.0	Peyronie's Disease.	C	YES NO
016.00.0	Burn Surgery.		YES NO
016.01.0	Debridement.		YES NO
016.01.1	With use of local anesthesia only.	A	YES NO
016.01.2	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO

*The class in the minimum facility category in which the procedures may be performed.

		*CLASS	
016.01.3	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO
017.00.0	Flaps.		YES NO
017.01.0	With use of local anesthesia only.	A	YES NO
017.02.0	With use of local anesthesia with intravenous, hypnotics, tranquilizers and/or dissociative agents.	B	YES NO
017.03.0	With use of general anesthesia and support of vital functions such as blood pressure, blood volume and respiration.	C	YES NO

*The class in the minimum facility category in which the procedures may be performed.

NOTE FOR THE INSPECTOR

Please write any comments concerning this section on the last page of this booklet and identify the question and page number. Your comments are valuable.

SECTION III

SURGERY FACILITY

To Be Completed by Inspector

		CLASS	
001.00.0	Does this facility have an operating room(s) whose function(s) is separate and distinct as an operating room.	B,C	YES NO
001.01.0	Does this facility have an examining room which also functions as an operating(s) room.	I	YES NO
001.01.1	If yes, is it used for major surgery.	A	YES NO
001.01.2	If yes, is it used for minor surgery.	A	YES NO
002.00.0	Is there an adequate waiting room area.	A,B,C	YES NO
002.01.0	Is the waiting room area adequately ventilated and temperature controlled.	A,B,C	YES NO
002.02.0	Does the waiting room have adequate lighting.	A,B,C	YES NO
002.03.0	Is the waiting room adequately maintained.	A,B,C	YES NO
003.00.0	Is there an adequate area for administrative activities.	A,B,C	YES NO
003.01.0	Is there sufficient space for the clerical personnel.	A,B,C	YES NO
003.02.0	Is there sufficient space for the appropriate storage of records.	A,B,C	YES NO
003.03.0	Is the administrative area properly lighted.	A,B,C	YES NO
003.04.0	Is the administrative area properly ventilated and temperature controlled.	A,B,C	YES NO
003.05.0	Is the administrative area properly maintained.	A,B,C	YES NO
004.00.0	Is there an adequate examination room(s).	A,B,C	YES NO
004.01.0	Is the examination room(s) properly ventilated and temperature controlled.	A,B,C	YES NO

		CLASS		
004.02.0	Does the examination room(s) have adequate lighting.	A,B,C	YES	NO
004.03.0	Is the examining room(s) appropriately equipped for its intended use.	A,B,C	YES	NO
004.04.0	Is the examination room(s) adequately maintained.	A,B,C	YES	NO
004.05.0	If the examination room(s) is used for minor surgical procedures, with appropriate sterility techniques.	A,B,C	YES	NO
005.00.0	Is there an adequate operating room(s).	A,B,C	YES	NO
005.01.0	Is the operating room(s) independently adequately ventilated and temperature controlled.	[illegible]	YES	NO
005.02.0	Is the operating room(s) adequately maintained.	A,B,C	YES	NO
005.03.0	Is ceiling surface free of particulate matter that can contaminate room. (e.g. asbestos ceiling tile)	B,C	YES	NO
006.00.0	Is there an appropriate physician(s) consultation office.	A,B,C	YES	NO
006.01.0	Is the office(s) adequately ventilated and temperature controlled.	A,B,C	YES	NO
006.02.0	Is there sufficient lighting in the office(s).	A,B,C	YES	NO
006.03.0	Is the office(s) adequately maintained.	A,B,C	YES	NO
007.00.0	Is there adequate storage space for supplies.	A,B,C	YES	NO
007.01.0	Is the storage space organized and free of clutter.	A,B,C	YES	NO
007.02.0	Is the storage space adequately maintained.	A,B,C	YES	NO
008.00.0	Is there an adequate recovery room(s) or area(s).	A,B,C	YES	NO
008.01.0	Is the recovery area adequately maintained.	A,B,C	YES	NO
009.00.0	Are there adequate passages or hallways.	A,B,C	YES	NO
009.01.0	Are the passage ways adequately maintained and free of clutter.	A,B,C	YES	NO
009.02.0	Are the passage ways adequately lighted.	A,B,C	YES	NO

		CLASS	
009.03.0	Is the width of the passage ways sufficient for access of emergency equipment or gurneys used in the facility.	A,B,C	YES NO
010.00.0	Are there adequate lavatory facilities for patients and personnel.	A,B,C	YES NO

NOTE FOR THE INSPECTOR

Please write any comments concerning this section on the last page of this booklet and identify the question and page number. Your comments are valuable.

SECTION IV

MEDICAL RECORDS

To Be Completed by Inspector

		CLASS		
001.00.0	Are medical records obtained and filed for easy accessibility.	A,B,C	YES	NO
002.00.0	Is appropriate patient information easily identifiable.	A,B,C	YES	NO
003.00.0	Is a history and physical performed on those patients whose age, medical condition and complexity of procedure so merit.	A,B,C	YES	NO
003.01.0	Does the following history include each of the following:			
003.01.1	Drug allergies.	A,B,C	YES	NO
003.01.2	Drug sensitivities.	A,B,C	YES	NO
003.01.3	Medication the patient is currently taking.	A,B,C	YES	NO
003.01.4	Previous serious illness.	A,B,C	YES	NO
003.01.5	Chronic continuing illness (under treatment).	A,B,C	YES	NO
003.01.6	Previous surgery.	A,B,C	YES	NO
003.01.7	Bleeding tendencies.	A,B,C	YES	NO
003.02.0	Does the physical exam adequately cover appropriute organs and organ systems commensurate with the anticipated procedure.	A,B,C	YES	NO
004.00.0	Is there an operative report on surgical cases.	A,B,C	YES	NO
004.01.0	Including unusual findings.	A,B,C	YES	NO
004.02.0	Including unanticipated difficulties.	A,B,C	YES	NO
004.03.0	Including operative technique.	A,B,C	YES	NO
005.00.0	Do you routinely obtain an operative permit on schedule cases.	A,B,C	YES	NO
005.01.0	Does the permit specifically authorize this surgeon by name to perform surgery.	A,B,C	YES	NO
005.02.0	Does the operative permit name or describe the operative procedure.	A,B,C	YES	NO

		CLASS	
005.03.0	Does the permit provide consent for administration of anesthetics under the direction of the surgeon.	A,B,C	YES NO
006.00.0	Are appropriate laboratory procedures performed where indicated.	A,B,C	YES NO
006.01.0	Are printed or written copies of the patient's laboratory results kept in the chart.	A,B,C	YES NO
006.02.0	Is a CBC routinely performed preoperatively on major cases.	B,C	YES NO
006.03.0	Is an urinalysis routinely performed on preoperative major cases.	I	YES NO
006.04.0	Is a PTT (Partial Thromboplastin Time) performed.	I	YES NO
006.05.0	Prothrombin Time, Platelet Count.	I	YES NO
006.06.0	Are basic lab tests (CBC, U/A) done in your facility.	I	YES NO
006.07.0	Are more sophisticated lab tests carried out in your office.	I	YES NO
006.08.0	If an outside laboratory is used, is it an appropriately licensed or accredited lab, and does its name appear on the report.	A,B,C	YES NO
007.00.0	Are printed pathology reports kept in the patient's record.	A,B,C	YES NO
007.01.0	Are pathology reports rendered by a board certified pathologist and is his name on the report.	A,B,C	YES NO
007.02.0	Does the physician have a system to make certain that all pathology reports are initialed by him.	A,B,C	YES NO
008.00.0	Are appropriate radiology reports kept in the patient's charts.	A,B,C	YES NO
009.00.0	Is an operative record maintained during and after surgery.	A,B,C	YES NO
009.01.0	Are all medications recorded.	A,B,C	YES NO
0[illegible] 01.1	Date given.	A,B,C	YES NO
009.01.2	Dose given.	A,B,C	YES NO
009.01.3	Time given.	A,B,C	YES NO
009.01.4	Appropriate clinical responses recorded.	A,B,C	YES NO

		CLASS		
009.02.0	Are the patient's vital signs recorded on the chart during surgery.	A,B,C	YES	NO
009.03.0	Are the patient's vital signs recorded post-operatively.	A,B,C	YES	NO
009.04.0	Is a separate anesthesia record maintained.	A,B,C	YES	NO
010.00.0	Is there a routine periodic peer review with random cases at the least, quarterly.	A,B,C	YES	NO
010.01.0	Are these meetings properly documented.	A,B,C	YES	NO
010.02.0	Are these reviews done through:			
010.02.1	a) Group Practice	A,B,C	YES	NO
010.02.2	b) Plastic Surgeons section of the medical staff of the hospital at which he/she holds admitting privileges	A,B,C	YES	NO
010.02.3	c) Peer Review Organizations	A,B,C	YES	NO

NOTE FOR THE INSPECTOR

Please write any comments concerning this section on the last page of this booklet and identify the question and page number. Your comments are valuable.

SECTION V

OPERATING ROOM PERSONNEL

To Be Completed by Inspector

		CLASS	
001.00.0	Is there one qualified or adequately trained person designated in a supervisory capacity to oversee the operation of the surgical area.	A,B,C	YES NO
002.00.0	If registered nurses are employed, are their licenses up-to-date.	A,B,C	YES NO
003.00.0	If licensed practical nurses are employed, are their licenses up-to-date.	A,B,C	YES NO
004.00.0	If surgical technicians are employed, are they trained by a qualified plastic surgeon.	A,B,C	YES NO
005.00.0	Do the operating personnel have the proper training and experience to be employed in the operating room.	A,B,C	YES NO
005.01.0	Are all operating room personnel trained in basic life support (CPR).	A,B,C,	YES NO
006.00.0	Do the operating personnel have an adequate knowledge of:		
006.01.0	Cardiac arrest.	A,B,C	YES NO
006.02.0	Respiratory arrest.	A,B,C	YES NO
006.03.0	Anaphylactic emergencies.	A,B,C	YES NO
007.00.0	Are the operating personnel familiar with the equipment utilized in the treatment of the above emergencies. (See #6).	A,B,C	YES NO
008.00.0	Are the operating personnel familiar with the medications commonly used in the treatment of the above emergencies. (See #6).	A,B,C	YES NO
009.00.0	Are the operating room personnel familiar with the procedural routine treatment of the above emergencies. (See #6).	A,B,C	YES NO
010.00.0	Do all operating room personnel understand.	A,B,C	YES NO
010.01.0	The indications for cardio-pulmonary resuscitation.	B,C	YES NO

		CLASS		
010.02.0	The responsibility during cardiopulmonary resuscitation.	B,C	YES	NO
010.03.0	Mouth to mouth technique.	B,C	YES	NO
010.04.0	The delivery of external cardiac massage.	B,C	YES	NO
010.05.0	The use of bag-mask ("Ambu" bag) devices.	B,C	YES	NO
010.06.0	The use of positive pressure mask devices (e.g. Elder valve, Robertshaw valve).	B,C	YES	NO
011.00.0	Is there a set written protocol for each of the emergency procedures below:			
011.01.0	Do you have regular cardiopulmonary resuscitation.	B,C	YES	NO
011.02.0	Do you have a means of calling all appropriate personnel for emergencies.	B,C	YES	NO
011.03.0	Do you have a written protocol for fire drills.	B,C	YES	NO
011.04.0	Do the personnel know how to operate fire extinguishers.	B,C	YES	NO
012.00.0	Do operative personnel have an adequate knowledge of the rationale for maintaining aseptic technique.	B,C	YES	NO
013.00.0	Do operating room personnel perform aseptic technique adequately in surgery.	B,C	YES	NO
014.00.0	Do operating room personnel know how to open autoclave packs without contamination.	B,C	YES	NO
014.01.0	Do operating room personnel know how to open commercial "peel down" sterile packs.	B,C	YES	NO
014.02.0	Do operating room personnel understand how to properly remove and transfer items from "soaker" sterilizing solutions.	B,C	YES	NO
015.00.0	Do operating room personnel routinely wear except for intra-oral or intra-nasal and skin procedures:			
015.01.0	Scrub suits.	B,C	YES	NO
015.02.0	Sterile operative gowns in surgery.	B,C	YES	NO
015.03.0	Operating room shoes or covers for conventional shoes.	B,C	YES	NO
015.04.0	Caps or hair covers.	B,C	YES	NO

		CLASS		
015.05.0	Operating room masks.	B,C	YES	NO
015.06.0	Does use of each of the above vary with the procedure.	I	YES	NO
016.00.0	Are all operating room personnel familiar with each of the following equipment:			
016.01.0	Mechanical operating room tables and chairs.	A,B,C	YES	NO
016.02.0	Operating room lights.	A,B,C	YES	NO
016.03.0	Suction equipment.	A,B,C	YES	NO
016.04.0	Cardiac monitoring equipment.	B,C	YES	NO
016.05.0	Defibrillator equipment.	B,C	YES	NO
016.06.0	Fiberoptic equipment.	B,C	YES	NO
016.07.0	Electrocautery.	A,B,C	YES	NO
016.08.0	Laryngoscope and endotracheal tubes.	B,C	YES	NO
016.09.0	Oral airways.	B,C	YES	NO
016.10.0	Esophageal airways.	B,C	YES	NO
016.11.0	Syringes and needles.	A,B,C	YES	NO
016.12.0	Delivery of oxygen.	A,B,C	YES	NO
016.13.0	Anesthetic gases where applicable.	C	YES	NO
016.14.0	Autoclave or sterilizer.	A,B,C	YES	NO
016.15.0	Gas sterilizer.	A,B,C	YES	NO
016.16.0	Setting up and administration of IV fluids.	A,B,C	YES	NO
016.17.0	Location of routine and emergency medications.	A,B,C	YES	NO
017.00.0	Which of the following personnel work in your operating room facility:			
017.01.0	Surgical technician.	I	YES	NO
017.02.0	Nurse - L.P.N. or L.V.N.	I	YES	NO
017.03.0	Nurse - R.N.	A,B,C	YES	NO

		CLASS	
017.04.0	Nurse anesthetist (C.R.N.A.)	C	YES NO
017.05.0	Physician's assistant.	I	YES NO
017.06.0	Anesthesiologist	C	YES NO
018.00.0	Personnel policies:		
018.01.0	Is there a manual outlining personnel policies.	A,B,C	YES NO
018.02.0	Are records maintained on all current employees.	A,B,C	YES NO
019.00.0	Do personnel records contain:		
019.01.0	Resume of training and experience.	A,B,C	YES NO
019.02.0	Formal certification or license if required by state.	A,B,C	YES NO
019.03.0	References.	A,B,C	YES NO
019.04.0	Date of employment.	A,B,C	YES NO
019.05.0	Description of duties.	A,B,C	YES NO
019.06.0	Record of continuing education.	A,B,C	YES NO
019.07.0	Record of advancement.	A,B,C	YES NO
019.08.0	Health record.	A,B,C	YES NO
019.09.0	Periodic evaluation of performance.	A,B,C	YES NO
019.10.0	Annual Physical.	I	YES NO

NOTE FOR THE INSPECTOR

Please write any comments concerning this section on the last page of this booklet and identify the question and page number. Your comments are valuable.

SECTION VI

OPERATING ROOM AND EQUIPMENT

To Be Completed by Inspector

		CLASS	
001.00.0	Does the operating room equipment meet the local and state standard for fire control and safety.	A,B,C	YES NO
002.00.0	Does the operating room equipment meet local, state and OSHA standards for safety codes.	A,B,C	YES NO
003.00.0	Does the operating room equipment meet local and state standards for sanitation codes.	A,B,C	YES NO
004.00.0	Is the building equipped with an automatic sprinkler system for fire protection.	I	YES NO
004.01.0	Heat sensors and smoke detectors.	I	YES NO
005.00.0	Is smoking prohibited in hazardous area.	A,B,C	YES NO
006.00.0	Are an adequate number and variety of fire extinguishers available.	A,B,C	YES NO
007.00.0	Does the facility utilize currently acceptable procedures to minimize sources and transmissions of infections.	A,B,C	YES NO
007.01.0	Are sterile and non-sterile supplies stored separately.	A,B,C	YES NO
007.02.0	Are acceptable procedures utilized for handling soiled drapes, used needles, etc.	A,B,C	YES NO
008.00.0	Are combustible materials and supplies stored and handled in a safe manner complying with local, state and OSHA codes and regulations.	A,B,C	YES NO
009.00.0	In your operating room, do you use any explosive agents.	A,B,C	YES NO
009.01.0	Is ether used.	A,B,C	YES NO
009.02.0	Is cyclopropane used.	A,B,C	YES NO
009.03.0	Is fluomar used.	A,B,C	YES NO
009.04.0	Are other explosive materials used.	A,B,C	YES NO
009.05.0	Are all properly stored in a safety room or appropriate cabinet in compliance with OSHA regulations.	A,B,C	YES NO

		CLASS		
010.00.0	Do you use any of the following types of anesthesia.	A,B,C	YES	NO
010.01.0	Local anesthesia (infiltration) only.	A,B,C	YES	NO
010.02.0	Local and pre-op sedation only.	A,B	YES	NO
010.03.0	Local and intravenous tranquilizers.	B,C	YES	NO
010.04.0	Local and intravenous barbiturate.	B,C	YES	NO
010.05.0	Local and intravenous hypnotic neuroleptic agent.	B,C	YES	NO
010.06.0	Local and intravenous narcotic.	B,C	YES	NO
010.07.0	Local and intravenous dissociative agent.	B,C	YES	NO
010.08.0	General inhalation (gaseous) anesthetics.	C	YES	NO
010.09.0	General inhalation (gaseous) anesthetics and a paralytic agent.	C	YES	NO
010.10.0	Local anesthetic block (major nerves).	C	YES	NO
010.11.0	Spinal block.	C	YES	NO
010.12.0	Tourniquet - IV lidocaine (xylocaine) block of an extremity.	B,C	YES	NO
011.00.0	Are all anesthetics given by the physician or under his direct supervision.	A,B,C	YES	NO
011.01.0	Do you use services of anesthesiologist or nurse anesthetist.	C	YES	NO
012.00.0	Are other types of medicaton dispensed to patients (Such as analgesic, antibiotics, hypnotics and tranquilizers).	I	YES	NO
012.01.0	Is there an area where routine medications are kept.	A,B,C	YES	NO
012.02.0	Is there a separate area where emergency medications are kept.	A,B,C	YES	NO
012.03.0	Is there some source of refrigeration for keeping drugs that require cold storage.	A,B,C	YES	NO
012.04.0	Is the refrigeration unit free of food or other non-medical items.	A,B	YES	NO
012.05.0	Is there a locked narcotic box.	A,B,C	YES	NO

		CLASS		
012.06.0	Is there a routine written protocol to maintain a a written account of the use of narcotics on individual patients.	A,B,C	YES	NO
012.07.0	Is the inventory of narcotics routinely checked and verified.	A,B,C,	YES	NO
012.08.0	Are medications routinely reviewed to remove and replace outdated drugs.	A,B,C.	YES	NO
013.00.0	Are proper controls instituted to prevent visitors or lay personnel from entering the operating room suite.	A,B,C,	YES	NO
013.01.0	Are visitors or lay personnel allowed in the recovery area.	A,B,C,	YES	NO
013.02.0	Are visitors or lay personnel called to the recovery area only after a patient is ready to leave.	A,B,C	YES	NO
014.00.0	Does the facility have a means for obtaining and administering blood or blood substitutes.	B,C	YES	NO
014.01.0	Are means available for the administering of the blood or blood substitute.	B,C	YES	NO
015.00.0	Does the operative suite contain conductive floors (if explosive anesthetics are used).	C	YES	NO
015.01.0	Is "properly grounded" equipment used in the operating room.	A,B,C	YES	NO
015.02.0	Is all equipment checked for leakage.	A,B,C	YES	NO
015.03.0	Are explosive proof electrical outlets used if explosive agents are used.	C	YES	NO
015.04.0	Are all circuits checked for polarity.	B,C	YES	NO
015.05.0	Are electrical outlets placed 5 feet off the floor if explosive gases used.	C	YES	NO
016.00.0	Does the operative suite have the availability of monitoring equipment.	B,C	YES	NO
016.01.0	Cardiac monitor.	B,C	YES	NO
016.01.1	With pulse read-out.	B,C	YES	NO
016.02.0	Pulse meter.	B,C	YES	NO
016.02.1	With pulse read-out.	B,C	YES	NO

		CLASS		
016.03.0	Pulse Oximeter.	B,C	YES	NO
016.04.0	Defibrillator.	B,C	YES	NO
017.00.0	Is the equipment in question 016.00.0 et.al. periodically checked for operability and voltage where applicable.	B,C	YES	NO
018.00.0	Is there breathing apparatus available in the operating rooms.	B,C	YES	NO
018.01.0	Airways (oral).	A,B,C	YES	NO
018.02.0	Esophageal airway.	B,C	YES	NO
018.03.0	Forced respiration mask-bag ("Ambu bag").	A,B,C	YES	NO
018.04.0	Elder or Robertshaw positive pressure mask-valve.	B,C	YES	NO
018.05.0	Laryngoscope.	B,C	YES	NO
018.05.1	Endotracheal tubes.	B,C	YES	NO
018.05.2	Endotracheal obturator.	B,C	YES	NO
018.06.0	Source of O_2.	B,C	YES	NO
018.07.0	A source of suction or suction apparatus.	B,C	YES	NO
019.00.0	Are sterile drapes routinely used during surgery.	A,B,C	YES	NO
019.01.0	Are drapes or linens autoclaved in the office.	A,B,C	YES	NO
019.02.0	Are drapes or linens autoclaved in a hospital or other facility.	A,B,C	YES	NO
019.03.0	Are pre-sterilized disposable drapes utilized.	A,B,C	YES	NO
020.00.0	Is there a plan for transferring emergency cases requiring unusual care.	A,B,C	YES	NO
021.00.0	Are appropriate operating room lights used.	A,B,C	YES	NO
021.01.0	Is the operating room provided with fluorescent or incandescent lights in the ceiling.	A,B,C	YES	NO
021.02.0	Is the operating room equipped with surgical lights or spot lights as well.	A,B,C	YES	NO

		CLASS	
021.03.0	Are surgical lights ceiling mounted.	I	YES NO
021.04.0	Are surgical lights on the floor.	I	YES NO
021.05.0	Are surgical lights part of the built-in operatory equipment (e.g. installed as standard equipment attached to the operating room table).	I	YES NO
021.06.0	Are there suitable emergency lights in case of a power failure.	A,B,C	YES NO
021.07.0	Do you use a head light.	A,B,C	YES NO
021.08.0	Do you use fibroptic devices.	A,B,C	YES NO
022.00.0	Is a suitable operating room table or chair provided which has full capabilities for the performance of all scheduled cases.	A,B,C	YES NO
023.00.0	Do you use electrocautery in the operating room.	A,B,C	YES NO
023.01.0	Unipoplar.	I	YES NO
023.02.0	Bipoplar.	I	YES NO
023.03.0	Do you employ the use of a ground plate.	A,B,C	YES NO
023.04.0	Are all safety measures employed during the use.	A,B,C	YES NO
023.05.0	Do you use "hot tip" or thermalcautery.	I	YES NO
023.06.0	Is there some source of cautery if there is a power failure (e.g. battery operated cautery or emergency power supply via generator).	B,C	YES NO
024.00.0	Does your facility have an autoclave or sterilizer.	A,B,C	YES NO
024.01.0	Is the accuracy and efficiency of your autoclave checked periodically by an approved method.	A,B,C	YES NO
024.02.0	Is the date of sterilization marked on all items wrapped and sterilized in the facility.	A,B,C	YES NO
024.03.0	Is there an established policy for the storage of sterilized supplies.	A,B,C	YES NO
024.04.0	Are sterile supplies appropriately labeled.	A,B,C	YES NO

		CLASS		
024.05.0	Are sterile supplies and equipment kept separate from unsterile supplies.	A,B,C	YES	NO
024.06.0	If a gas sterilizer is used, is the proper aeration time utilized.	A,B,C	YES	NO
024.07.0	Is the autoclave checked at least monthly for temperature and sterility requirements with spare strips, ampules or other means.	A,B,C	YES	NO
025.00.0	Are emergency medications readily available.	A,B,C	YES	NO
025.01.0	IV fluids.	A,B,C	YES	NO
025.01.1	Ringers lactate (with or without dextrose).	A,B,C	YES	NO
025.01.2	Normal saline (with or without dextrose).	A,B,C	YES	NO
025.01.3	D_5W.	A,B,C	YES	NO
025.02.0	Epinephrine	A,B,C	YES	NO
025.03.0	Sodium bicarbonate.	A,B,C	YES	NO
025.04.0	Xylocaine - plain.	A,B,C	YES	NO
025.05.0	Vasopressors other than epinephrine.	I	YES	NO
025.06.0	Narcotic anatagonist (e.g. narcan, lorphan, etc.).	B,C	YES	NO
025.07.0	Seizure arresting medication (e.g. valium, barbiturates, dilantin, etc.).	A,B,C	YES	NO
025.08.0	Intravenous corticosteroids (to treat anaphylaxis).	A,B,C	YES	NO
025.09.0	Antihistamines (to treat anaphylaxis).	A,B,C	YES	NO
026.00.0	Is the operating room regularly cleaned in accordance with customary protocol.	A,B,C	YES	NO
027.00.0	Is the entire operating room suite cleaned regularly according to an established routine.	A,B,C	YES	NO
028.00.0	Is there an adequate recovery area.	A,B,C	YES	NO
028.01.0	Is the patient under direct personnel supervision.	B,C	YES	NO
028.02.0	Is the patient under indirect personnel supervision.	B,C	YES	NO

		CLASS		
028.02.1	By telemetry.	B,C	YES	NO
028.02.2	By monitoring.	B,C	YES	NO
028.02.3	By intercom.	A,B,C	YES	NO
028.03.0	Is there some means by which the recovering patient can notify the personnel of problems.	A,B,C	YES	NO
028.03.1	Is there a buzzer.	A,B,C	YES	NO
028.03.2	Is there a monitor.	A,B,C	YES	NO
028.03.3	Is there an intercom.	A,B,C	YES	NO
028.04.0	Are the patient's vital signs observed in the recovery area.	B,C	YES	NO
028.04.1	Pulse.	B,C	YES	NO
028.04.2	Blood pressure.	B,C	YES	NO
028.04.3	Sensorium.	B,C	YES	NO
028.04.4	Respirations.	B,C	YES	NO
028.05.0	Are any vital signs recorded on the patient's permanent records (recovery area) where indicated.	A,B,C	YES	NO
028.05.1	Pulse.	A,B,C	YES	NO
028.05.2	Blood Pressure.	A,B,C	YES	NO
028.05.3	Sensorium.	B,C	YES	NO
028.05.4	Respirations.	B,C	YES	NO
028.06.0	Are patients checked for physiological stability before discharge from the recovery area.	A,B,C	YES	NO
028.06.1	Vital signs.	A,B,C	YES	NO
028.06.2	Sensorium.	B,C	YES	NO
028.07.0	Are patients permitted to leave the recovery area:	A,B,C	YES	NO
028.07.1	On their own (No assistance).	I	YES	NO
028.07.2	With assistance only.	I	YES	NO

		CLASS	
028.07.3	Wheelchair.	I	YES NO
028.07.4	Stretcher.	I	YES NO
028.08.0	Are post-operative patients given adequate instructions before returning home.	A,B,C	YES NO
028.08.1	Verbal instruction.	A,B,C	YES NO
028.08.2	Printed instructions.	A,B,C	YES NO
028.09.0	Post-operative instruction are routinely given before leaving office.	A,B,C	YES NO
028.09.1	The patient only.	I	YES NO
028.09.2	Accompanying friend or relative.	I	YES NO
028.10.0	Do you transfer the post-operative patients.	A,B,C	YES NO
028.10.1	Home.	A	YES NO
028.10.2	Intermediate care facility.	B,C	YES NO
028.10.3	Hospital.	B,C	YES NO
028.10.4	Hotel/Motel.	B,C	YES NO
028.11.0	Post-operative patients are transported from your facility by:		
028.11.1	Private car-patient drives.	A	YES NO
028.11.2	Private car-driver other than patient.	B	YES NO
028.11.3	Taxi.	A,B	YES NO
028.11.4	Ambulance.	B,C	YES NO
028.11.5	Special patient transfer vehicle.	B,C	YES NO
028.12.0	Do you ever keep patients overnight in your facility.	B,C	YES NO
029.00.0	Do you have an anesthesia machine.	C	YES NO
029.01.0	Does your anesthesia machine have an 0_2 monitor.	C	YES NO
029.02.0	Does your anesthesia machine have a purge system to extract the gaseous airs to the outside.	C	YES NO

NOTE FOR THE INSPECTOR

Please write any comments concerning this section on the last page of this booklet and identify the question and page number. Your comments are valuable.

SECTION VII

SANITATION AND HOUSEKEEPING

To Be Completed by Inspector

		CLASS		
001.00.0	Have State and Federal regulations been reviewed where applicable.	A,B,C	YES	NO
002.00.0	Is all waste stored in appropriate containers.	A,B,C	YES	NO
003.00.0	Is all biological waste disposed of in a manner to prevent transmission of disease.	A,B,C	YES	NO
004.00.0	Are all openings to outside air effectively protected against the entrance of insects, animals, etc.	A,B,C	YES	NO
005.00.0	Are proper scrub facilities provided for the surgeon and personnel.	A,B,C	YES	NO
006.00.0	Is dry sweeping or dusting prohibited in the operating room.	A,B,C	YES	NO
007.00.0	Are passage ways free of clutter.	A,B,C	YES	NO
008.00.0	Are floors adequately cleaned and maintained.	A,B,C	YES	NO
009.00.0	Are walls and ceiling cleaned.	A,B,C	YES	NO
010.00.0	Are ceilings in the operating room smooth surfaced.	A,B,C	YES	NO
010.01.0	Are ceilings free of particulate matter that may drop into the operating room (e.g. asbestos ceiling tile).	B,C	YES	NO
011.00.0	Are bench top and sinks clean and well maintained.	A,B,C	YES	NO

NOTE FOR THE INSPECTOR

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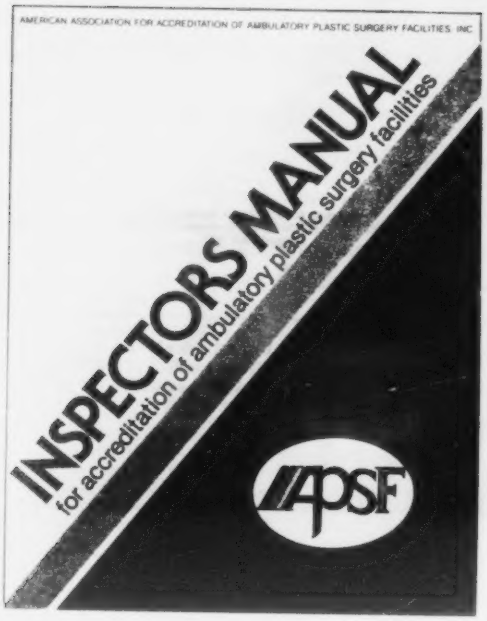

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC

INSPECTORS MANUAL

for accreditation of ambulatory plastic surgery facilities

AMERICAN ASSOCIATION FOR ACCREDITATION OF
AMBULATORY PLASTIC SURGERY FACILITIES, INC.

AAAAPSF ACCREDITATION OFFICE
1202 Allanson Rd./Mundelein, Illinois 60060
(312) 949-6058

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AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC.

Contact: Edward J. Stygar, Jr.
Executive Director
1202 Allanson Rd./Mundelein, IL 60060

FOREWORD

The Inspector's Manual is intended to serve as a General Guideline to the inspectors who will be inspecting Surgical Facilities. This will help to insure a certain level of quality in any inspection performed for the AAAAPSF. General Policies and Procedures are outlined in this book as a complement to attendance at Surgical Facility Seminars.

The Inspectors responsibility is one of an evaluator. This includes an objective on site review at the facility, its equipment, quality control, medical records, personnel, and sanitation and housekeeping. After the on site inspection, a determination if the facility meets AAAAPSF Standards is made. The Inspector also has an educational responsibility when inspecting a facility. This includes an explanation of the standards and suggestions for corrections in a positive manner of any deficiencies found in the surgical facility.

PEER REVIEW: This program is for voluntary accreditation of plastic surgery facilities inspected by physicians who have plastic surgery facilities and are certified by the American Board of Plastic Surgery. The primary goal of this organization is improvement of patient care through improved service and performance. This is accomplished by objective evaluation and positive criticism. A negative criticism does not reflect well on yourself or the organization.

STANDARDS: The standards are the fundamental tenets of the organization and the criteria against which all facilities are judged.

This is a document which should be reviewed and questioned until it is understood before inspection of a facility. Your complete understanding is important especially if you are questioned by an Inspectee. The Inspectors function is to explain - to debate any point is not his job. Any challenge to debate can be handled by inviting the Inspectee to send any suggestions or complaints to the Standards Committee of the AAAAPSF.

COMPLETENESS: The inspector is asked to conduct a complete and thorough inspection with appropriate attention to the Checklist.

Objectivity is key to a good inspection of a facility. A facility's personnel will expect a tough but fair appraisal of their facility. A weak uneven inspection will disappoint the Inspectee and reflect poorly on the program.

DECISIONS: The Association relies on your judgement in regards to the checklist. Your judgement is difficult to standardize or categorize. We expect you to use the Checklist as your guide but there will be times when a particular question will be in a "grey area". The Inspector must decide if the Inspectee has met the intent of the question as it relates to the standards.

Sometimes compliance to a deficiency can be achieved on the spot. The facility director can rewrite or institute a policy which will put him back in compliance with the standards. The Inspector will have to decide whether a problem is unusual or one of many irregularities within the facility. If there are many irregularities this must be reported.

Any difficult decision should be explained in detail in the supplemental letter and the Committee will take the explanations under advisement.

I. PREPARATION FOR INSPECTION

Appointment of the Inspectors will be made by the Inspector's Committee.

• Basis for Selection:

The Inspector selected should be a "peer" in his professional status, in the size of the surgical facility he operates, and specialization for procedures performed within his practice. The Inspector should also be from an accredited facility and have attended an office facility improvement symposium.

This cannot always be accomplished, but will be strived for. The Inspector should be from a different city and not from a competitive facility. The Inspector should not be closely acquainted with the Facility Director or other physician members of the staff.

• Contact of the Inspector:

The Inspectors should be contacted by telephone and confirmed by letter by the Inspector's Committee.

• Notification of Assigned Inspector:

The facility director will be notified of the Inspector assignment by a letter from the Inspector's Committee or the AAAA-PSF National Office.

The facility director will have the right to refuse the Inspector assigned. After three refusals the association has the right to send an Inspector deemed appropriate by the association.

• Arranging for an Inspection Date:

1. Contact the Facility Director and select a mutually convenient date within four weeks.
2. Write a letter confirming the date and give the facility director initial instructions regarding the inspection.
3. Notify the AAAAPSF National Office of the agreed upon inspection date immediately.

• Inspectors Portfolio:

The portfolio received from the AAAAPSF National Office will include the following:

1. The questionnaire completed by the Facility.
2. A copy of the Standards of AAAAPSF.
3. The Checklist for completion by the Inspector.
4. Inspector's Manual.

• Preliminary Evaluation:

Review the Questionnaire, the curriculum vitae of the facility director and the medical staff. This review will provide you with a preliminary knowledge of the size of the facility, the procedures performed and the type of practice of the physicians within the facility.

THE FOLLOWING IS A SAMPLE LETTER FROM THE INSPECTOR TO THE FACILITY DIRECTOR TO CONFIRM THE INSPECTION DATE AND PROVIDE INITIAL INSTRUCTIONS:

Dear Doctor________________:

This letter is to confirm our telephone conversation regarding the inspection of your surgical facility. I plan to arrive on________ at________and plan to be finished by______.

I would like to meet with you and your facility staff to provide everyone with a general outline of what will occur during the inspection.

Please have a work area available for my use during the inspection.

After the inspection is completed I would again like to meet with the facility staff for a summary conference to review the findings and clear up any questions that you or I may have.

Yours truly,

____

II. CONDUCTING THE INSPECTION

- **Preliminary Interview:**

Initially meet with the Surgical Facility Director and ask the director if he can familiarize you quickly with the layout of the facility. Also have him introduce you to the facility staff, and explain the inspection process and what you may require. Request the director to allow you to go through the facility by yourself, tell him you will meet with him after the completion of the inspection. Also inform him that you may request to review copies of records, policies and any other documents that may assist you in verifying answers to questions in the Checklist.

- **Inspection of the Facility:**

Complete the Checklist by circling one of the two choices available (YES or NO) for every question. If there is not an obvious answer to a question ask the staff to clarify and then using your best judgement choose the answer.

A "NO" answer will produce a deficiency and corrective statement on the report to the Facility Director. Questions marked "YES" will not require a corrective statement.

SECTION III - refers to the physical - plant of surgical facility i.e. examination room, operating room, waiting room, storage space, recovery room, etc.
SECTION IV - Medical Records. This section covers patient histories, medical reports, etc.
SECTION V - Operating Room Personnel. This section covers the personnel, their knowledge, practices, etc.
SECTION VI - Operating Room and Equipment. This section covers equipment, its use, handling or protocols.
SECTION VII - Sanitation and Housekeeping. This covers whether the facility has proper sanitation procedures and meets regulations.

- Peer Review:

Surgeons practicing in ambulatory plastic surgery facilities must participate in a peer review program. Group Practice Plastic Surgeons may form their own "in house" peer review program. Periodically (at least once quarterly) random cases and cases with complications shall be reviewed. All the meetings, the findings and the disposition of these cases must be appropriately documented.

Solo practitioners, within their own plastic surgery facility, may form a review committee with other members of the plastic surgery section of the medical staff at the hospital in which he/she holds admitting privileges. Once again, at least quarterly meetings shall be held to review random cases and cases with complications and the results of these meetings shall be recorded and properly documented.

Similar organizations of plastic surgeons may also be established for the purpose of peer review and if the formation of peer review groups cannot be established, the surgeon should participate in an established peer review organization.

As an inspector, your responsibility is to ensure that appropriate participation, in a peer review program, by the surgeons in the facility exists and is appropriately documented.

III. SUMMATION CONFERENCE

The summation conference is an especially important part of the inspection, because it leaves the final impression with the director and facility personnel of the Accreditation Program.

At the completion of the on site inspection, all parts of the checklist must be completed. Upon completion of the checklist, meet with the Facility Director and other medical staff to review your findings and clarify any further questions you may have and allow a dialog between the staff and you. Do not discuss or make a judgement statement as to the passing or failing of the facility. Only the questions marked "NO" should be reviewed with the staff to allow for improvement. If possible, provide corrective information for the deficiencies.

This whole process of inspection is educational. The summation conference is the appropriate time to address the educational objectives of the Surgical Inspection Program. Any questions regarding standards or their interpretation should be handled at this time. The complete evaluation and report will take between four to six weeks to complete by the Association. The Data is processed at the Computer Center and reviewed by the committee. The report and recommendations will be sent to the facility director by the Association as soon as it is completed.

If the Facility Director is not familiar with the accreditation process, you can explain to him that it is based on a review of all the objective components in the Checklist. All of these components are important to a well run facility to provide quality patient care.

Thank the Director for his time and support of the Surgical Accreditation Program. If the facility has been found to be a quality facility and you believe the Director and/or his associates would be an appropriate Inspector, ask them if they would be willing to serve as an Inspector and forward their names to the AAAAPSF National Office.

A follow-up letter to the Director is not necessary, but can be sent by the Inspector as a courtesy. The letter should not address the findings during the inspection, but thank the Director for the courtesies extended.

IV. INSPECTION REPORT

In addition to the Questionnaire/Checklist an Inspector's supplemental letter should be filed. The Inspector should outline any major concerns, deficiencies or explanations which need to be clarified or expanded that may seriously affect the operation of the Surgical Facility. If none are found this should also be noted in the letter.

• Return of the Inspectors Portfolio:

The completed supplemental letter and portfolio should be returned to AAAAPSF Accreditation Office.

Everything should be returned except any instructions forwarded to the Inspector and copies of the Standards. The portfolio should include:

1. Questionnaire/Checklist with all questions completed.
2. Inspector's supplemental letter.

• Recommendations for Accreditation:

It is not the function of the Inspector to make final judgements or statements to the Inspectee concerning the accreditation status of the facility. The final judgement shall be made by the Operating Committee. All recommendations should be filed with the committee and not discussed with the Inspectee.

FINAL COMMENT:

The success of the program is dependent on the professionalism and objectivity of the Inspector. It must be remembered that the Inspector is the association's representative and image to the Inspectee. We hope that the Inspectee will be left with a positive professional and educational experience.

Return all materials to:
AAAAPSF Office
1202 Allanson Road
Mundelein, IL 60060

FACT SHEET

1988 TREATMENT LOCATIONS AND FEE RANGES FOR ASPRS COSMETIC PATIENTS

	AVERAGE FEES		TREATMENT LOCATION			
Procedure	High	Low	Office	Free-Standing	Hospital Outpatient	Hospital Inpatient
Breast augmentation	$2,370	$1,970	50%	19%	27%	4%
Breast lift (mastopexy)	2,830	2,240	42%	13%	27%	18%
Breast reduction	3,850	3,090	9%	47%	34%	10%
Cheek augmentation	1,680	1,400	64%	16%	13%	7%
Chemical peel	1,270	680	77%	9%	9%	5%
Chin augmentation (mentoplasty)	1,160	820	56%	15%	21%	8%
Collagen injections	240	170	99%	<1%	0%	0%
Dermabrasion	1,300	620	56%	11%	26%	7%
Ear pinning (otoplasty)	1,810	1,490	37%	15%	41%	7%
Eyelid surgery (blepharoplasty)	2,330	1,800	62%	11%	22%	5%
Facelift (rhytidectomy)	3,860	2,980	58%	11%	14%	17%
Fat injections	570	320	90%	3%	7%	0%
Forehead lift	1,920	1,430	61%	16%	16%	7%
Hair replacement	1,340	820	70%	7%	17%	6%
Liposuction	1,750	830	46%	15%	30%	9%
Nose reshaping (rhinoplasty)	2,580	1,710	35%	14%	33%	18%
Retin-A*	64	30	100%	0%	0%	0%
"Tummy tuck" (abdominoplasty)	3,390	2,540	33%	8%	24%	35%

NOTE: Fees listed represent average highs and lows for the entire country. Costs could vary significantly from these estimates depending on the geographic location, complexity of the particular operation, etc. Treatment locations represent those surgeries performed in the doctors' offices, free-standing surgi-centers and hospitals.

*Estimated fees for Retin-A are based on the per visit cost, excluding the expense for the medication itself.

Quality control in ambulatory surgery

by George L Hoffmann, MD, FACS, Mesa, AZ

Quality control in ambulatory surgery was selected as a topic for the young surgeons' meeting because of the College's deep concern over the quality of surgery performed in ambulatory-care settings, particularly in freestanding facilities that advertise cosmetic procedures.

In January of 1981, the College published a statement on ambulatory surgery (*Bulletin*, page 65) that expresses general approval of the concept of ambulatory surgery. "Of prime concern," the statement says, "is assurance of quality." The statement mentions a number of benefits of ambulatory care, such as cost savings for the patient and convenience for both the physician and the patient. The statement also points out that any duplication of existing hospital facilities could, however, increase the cost of health care to the community. According to the statement, the major considerations in evaluating ambulatory-care facilities should be "the patient's suitability for ambulatory surgery as well as the provision of proper standards for physician privileges and facility accreditation."

Amublatory surgery is not a new concept. Surgeons have been doing outpatient procedures since the barber surgeons and before. Frederick Christopher's textbook *Minor Surgery*, which was published in 1930, and L. K. Ferguson's *Surgery of the Ambulatory Patient*, first issued in 1942, dealt with ambulatory surgery.

The modern impetus to the ambulatory-surgery movement, however, began about 11 years ago. At that time, two anesthesiologists, Wallace Reed and John Ford, mortgaged their homes and built the "Surgicenter" (a registered trademark name) in Phoenix.

At the outset, Drs. Reed and Ford said that they would not permit abortion and set up a local review board that had no financial interest in the facility. They also set up committees of appropriate specialists to review the work done in the facility, much as surgical committees do in hospitals. Privileges were accorded to surgeons consonant with the privileges they held in nearby hospitals. The center recently reported that since its inception the Surgicenter® has performed more than 70,000 procedures without fatalities or emergency hospital transfers. There are, of course, many other facilities throughout the United States, both hospital-affiliated and freestanding, that are doing similar good work.

> ***"The modern impetus to the ambulatory-surgery movement began about 11 years ago when two anesthesiologists built the 'Surgicenter' in Phoenix."***

Impressive statistics

The Freestanding Ambulatory Surgical Association, which includes about 100 members nationwide, recently reported on the results of surgical procedures performed in some 36 freestanding facilities. The statistics are impressive: Since 1972 nearly half a million procedures have been performed without fatality. Two hundred and thirty-three of the patients were transferred to hospitals; 89 of the transfers were unanticipated and eight were emergency transfers.

One reason these facilities have been able to maintain such an impressive record is that they care for a highly select group. One report showed that only 3.5 percent of their patients were over 60 years of age; this distribution is

A Regent of the College and a member of the fellowship and finance committees, Dr. Hoffmann is a general surgeon in private practice in Mesa, Arizona.

the obverse of my practice and probably yours.

Accreditation

In addition to obtaining state licenses and certificates of approval, ambulatory-care facilities must meet certain standards set by various accreditation agencies. One of these, the Joint Commission on Accreditation of Hospitals (JCAH), accredits both hospital-affiliated and freestanding ambulatory-care facilities. Hospital-affiliated facilities undergo the same survey process as do hospitals in general. The JCAH imposes the same standards for both hospital-affiliated and freestanding facilities, but surveys freestanding facilities in a slightly different fashion.

The other main ambulatory-care accrediting agency is the AAAHC (Accreditation Association for Ambulatory Health Care). In addition to accrediting freestanding ambulatory-care facilities, this group surveys university health services; community health services; group practices; and Indian-health, public-health, and uniformed-services health centers. The AAAHC surveys ambulatory-care facilities in such places as the Cleveland Clinic, the Geisinger Clinic, the Lovelace Clinic, and the Mason Clinic.

In addition, there are two smaller accrediting bodies: the American Association for Accreditation of Ambulatory Plastic Surgical Facilities (AAAAPSF) and the Society of Office Based Surgery.

In 1952, the College relinquished hospital surveying, which it had done since 1917, to the newly established JCAH. The AAAHC came about when the Joint Commission was reorganized in 1978. At that time the Joint Commission had accreditation councils that actually accredited the various types of facilities. When the JCAH was reorganized, its Board of Commissioners became responsible for accreditation, and in essence the accreditation councils became professional and technical advisory committees. The ambulatory-surgery council members became dissatisfied with this secondary role and withdrew from the JCAH. They joined with a few other groups and formed the AAAHC.

Incidentally, if you look at the Joint Commission's survey manual for freestanding facilities and the AAAHC's manual for freestanding facilities, you will notice that those manuals are presently the same, word for word. Although written standards for both accrediting agencies are the same, they may be enforced differently.

> ***"In addition to obtaining state licenses and certificates of approval, ambulatory-care facilities must meet certain standards set by various accreditation agencies."***

In recent years, the Joint Commission has surveyed about 94 ambulatory-care facilities, but only six of them were freestanding, and it has not surveyed freestanding facilities in the last year. The AAAHC has surveyed more than twice as many ambulatory-care facilities as has the Joint Commission, and this year alone, it will survey about 65 facilities.

In an effort to assure the quality of outpatient cosmetic surgery, the AAAAPSF was formed to accredit and survey facilities engaged in this type of activity. To be accredited by the AAAAPSF, the facility must be owned and operated by a board-certified plastic surgeon.

Dr. Wallace Reed, one of the anesthesiologists who started the Phoenix Surgicenter®, feels that an outpatient facility need not have the same capabilities as a hospital because it is a setting for selected procedures and selected patients. Although Dr. Reed agrees that the kind of records hospitals keep on patients and operations are appropriate for the hospital setting, he feels that they are probably too elaborate for an outpatient facility. Some physicians might disagree with Dr. Reed on this point.

Rule of 40

About ten years ago, I became interested in the ambulatory-surgery field and had the opportunity to chair a panel on this subject for the Governors of the College. I went around to many of the facilities and talked with many people. One number kept coming up, and from it I deduced what I call my "Rule of 40." The rule is that about 40 percent of the operations done at the community level can be done on an outpatient basis. In addition, if you wanted to set up an outpatient facility, you would need to perform approximately 40 operations a month per operating room to make the facility cost-effective. Frequently, an operation can be performed in an outpatient facility for 40 percent of what it would cost in a hospital. My friends involved in freestanding facilities have asked me to add a fourth corollary to my rule: About 40 percent of the cost can be saved by performing an operation in a freestanding facility instead of in a hospital-affiliated one, which has higher overhead. This last point might be debatable.

> ***"The Rule of 40 is that about 40 percent of the operations done at the community level can be done on an outpatient basis."***

Obviously accreditation agencies cannot prevent or solve all of the problems associated with quality control of ambulatory surgery. I think that as Fellows of the College, our responsibility is to exert leadership on the local as well as national levels to make sure that College principles influence the quality of operations done in an ambulatory-surgery setting.

WORKSHOP REPORT

Of the sixteen young surgeons who participated in the workshop on ambulatory-surgery, seven were general surgeons, four were urologists, three were orthopaedic surgeons, one was a vascular surgeon, and one was an otolaryngologist. The panel began its discussions by reviewing the College's statement regarding ambulatory-surgery facilities: "The American College of Surgeons approves of the practice of performing certain operative procedures in ambulatory-care facilities provided that appropriate quality assurance measures are in force. Of prime concern is the patient's suitability for ambulatory surgery as well as the provision of proper standards for physician privileges and facility accreditation." The panel unanimously agreed with the College's statement and directed its attention to the issue of quality control of these facilities.

The original ambulatory-surgery facilities were born out of need; they were primarily freestanding facilities that were financed and run by a group of physicians. Quality-control standards in these facilities included: careful patient selection, evaluation of the patient's risks from anesthesia, and the need for an operation. The panel concluded that the original facilities had maintained these standards because their physicians were personally and financially responsible for the operation of the facilities. Because the original facilities were so successful, a number of others have sprung up rapidly. The panel felt that this sudden upsurge in the number of ambulatory-care facilities has brought about a number of substandard facilities. To enhance quality assurance, the workshop recommended that the College participate in accrediting agencies such as the AAAHC. The workshop group also recommended that the College pursue the problem of substandard ambulatory-care facilities in its public information program.

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • Fax (312) 645-4184 • Telex 28-0248

JAMES H. SAMMONS, M.D.
Executive Vice President

January 18, 1989

TO: Delegates and Alternate Delegates
State Medical Associations
National Medical Specialty Societies
State and Specialty Society Presidents and Presidents Elect
County Medical Societies

SUBJECT: **ACTIONS TAKEN BY AMA HOUSE OF DELEGATES**
Interim Meeting, Dallas, Texas
December 4-7, 1988

Attached are the **ACTIONS TAKEN BY THE AMA HOUSE OF DELEGATES** at its Interim Meeting held in Dallas, Texas, December 4-7, 1988.

This information will serve as a record of the House of Delegates actions until the complete Proceedings of the 1988 Interim Meeting are available.

Sincerely,

James H. Sammons, M. D.

21. RESOLUTION 45 – CPT-4 GUIDELINES

Resolution 45 called upon the AMA to instruct its representatives on the Current Procedural Terminology (CPT) Editorial Panel to make their decisions in a fashion that accurately reflects current practice patterns , and to implement those changes which are brought forward with the full support of a national medical specialty society.

RESOLUTION 45 REFERRED TO BOARD OF TRUSTEES

22. RESOLUTION 5 – REVISION OF
MEDICARE "24 HOUR HOLD"

Resolution 5 asked that the AMA negotiate with the Health Care Financing Administration for a change in the "24 hour hold/observation" rule and permit these patients to remain in the hospital until a more acceptable dismissal time or until satisfactory transportation can be arranged, and that an order by the attending physician be necessary for the patient's status to be changed to a true inpatient admission.

RESOLUTION 5 ADOPTED

23. RESOLUTION 53 – INSURANCE PAYMENT TO PHYSICIANS
FOR TECHNICAL AND/OR FACILITY FEES

Resolution 53 called upon the AMA to vigorously pursue dialogue with the appropriate officials of the Health Care Financing Administration to communicate the urgent need to develop a mechanism for physician payment of a technical or facility fee, for example Medicare Code A4550, for service provided in their offices, and report to the House of Delegates at the 1989 Interim Meeting.

RESOLUTION 53 ADOPTED

24. REPORT C OF COUNCIL ON MEDICAL SERVICE
LAST-YEAR-OF-LIFE HEALTH INSURANCE
(RESOLUTION 46, I-87)

Report C of the Council on Medical Service discussed several alternative approaches to a separate health insurance vehicle for the "last-year-of-life" and concluded that current Association policy adequately addresses these issues.

**REPORT C OF COUNCIL ON MEDICAL SERVICE ADOPTED
IN LIEU OF RESOLUTION 46 (I-87)**

25. RESOLUTION 31 – HEALTH INSURANCE:
BEFORE AGE 65 RETIREES

Resolution 31 asked that the AMA study the problem of affordability and unavailability of health insurance for those who retire prior to Medicare eligibility.

RESOLUTION 31 ADOPTED

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 53
(I-88)

Introduced by: **Pennsylvania Delegation**

Subject: **Insurance Payment to Physicians for Technical and/or Facility Fees**

Referred to: **Reference Committee G**
(Robert H. Shackelford, M. D., Chairman)

Whereas, The trend to outpatient performance of many procedures encourages their performance in the physician's office for cost savings; however, the added expense to the physician in the office setting for personnel, equipment and other overhead charges is not currently reimbursed or paid by health insurers; and

Whereas, Medicare has made a "support component" eligible for payment in legislation (Section 1833 of the Medicare Law) but never has developed regulations for or a method of determination of payment of this technical component; and

Whereas, The coding mechanisms under CPT-4 (Current Procedural Terminology) provides appropriate coding for "supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered" (99070, 99071) and surgical trays (A4550); and

Whereas, Blue Shield refuses in principle to pay any technical component or tray charges to facilities or physician offices; and

Whereas, Medicare does pay "Tray Charges" to certain physicians on a case-by-case basis by adding an allowance to the normal physician allowances indicated on the Explanation of Benefits statements; and

Whereas, Medicare has demanded that certain Peer Review Organizations develop a list of outpatient procedures to be performed in physicians' offices; therefore be it

RESOLVED, That the American Medical Association vigorously pursue dialogue with the appropriate officials of the Health Care Financing Administration to communicate the urgent need to develop a mechanism for physician payment of a technical or facility fee, for example Medicare Code A4550, for service provided in their offices, and report to the House of Delegates at the 1989 Interim Meeting.

Fiscal Note: $1,000-$1,500

APPROVED BY AMA HOUSE OF DELEGATES 6/20/89

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 99
(A-89)

Introduced by: Louis F. Alfano, M. D., Delegate
American Society of Abdominal Surgeons

Subject: Identification of Board Certified Physicians

Referred to: Reference Committee C
(Lewis H. Biben, M. D., Chairman)

Whereas, Physicians sometimes identify themselves as being "board certified" without stating the full name of the certifying board; therefore be it

RESOLVED, That the American Medical Association urge physicians to identify themselves by stating the full name of their certifying board.

Fiscal Note: $1,000

Mutual of Omaha Insurance Company ■ Home Office: Mutual of Omaha Plaza, Omaha, Nebraska 68175 ■ (402) 342-7600 ■ V. J. Skutt, Chairman of the Board ■ J. D. Minton, President

Mutual of Omaha.
People you can count on...

RECEIVED OCT 2 4 1986.

October 20, 1986

American Association For Accreditation
of Plastic Surgery Facilities
505 East Hawley Street
Mundelin, ILL 60060

RE: Office Based Surgery

The International Claims Association held their annual convention in Boston Massachusetts the week of September 21, 1986. That association is made up of 465 participating health and life insurance companies and the convention was attended by in excess of 1000 representatives of those companies.

In preparation for this convention, certain members serve on committees for various workshops, and prepare material for workshop books. I was on a committee for Managed Health Care, and chose the subject of Office Based Surgery for my subject. Attached is a copy of the paper that was presented to the International Claims Association on based surgery. I felt that you would appreciate having a copy of this for your records.

It was of interest to me that several individuals affiliated with rather large insurance organizations were unaware of the savings to be achieved through taking advantage of office based surgical facilities, and hopefully this will assist in your efforts to conserve costs for your patients.

Sincerely,

Lowell Madsen

Lowell Madsen
Assistant Vice President
Group Claims Administration

Affiliated Companies: United of Omaha ■ Omaha Indemnity ■ Omaha Property and Casualty ■ Companion Life Insurance Company ■ Omaha Financial Life Insurance Company ■ Tele-Trip Company ■ Constitution Insurance Company of Canada ■ Mutual of Omaha Fund Management Company, Sponsor of Mutual of Omaha Funds ■ Kirkpatrick, Pettis, Smith, Polian Inc., Investment Bankers ■ Mutual of Omaha International Ltd., London, England

OFFICE BASED SURGERY

CONSERVING BENEFITS DOLLARS . . . Everyone is interested in this, especially when it can be done without financial impact on the individual receiving medical services and without impairing the quality of care or restricting access to necessary care. The cost advantages of surgery occurring in an ambulatory surgery facility as opposed to the expense of inpatient hospital surgery are well known. What is not so well known are the significant savings to be realized by encouraging use of surgical suites in the physician's office setting. Here are some examples:

	Facility Charges		
Surgical Procedure	Office Based Surgery Cost	Ambulatory Surgery Facility	Hospital Inpatient
Open Breast Biopsy			
* Level 1 or 2	$ 150		
Level 3	350	$ 600	$ 1,000
Inguinal Hernia			
Unilateral			
Level 1 or 2	150		
Level 3	350	800	1,300
Dilatation &			
Curettage			
Uterus			
Level 1	100		
Level 2	150		
Level 3	350	450-760	1,325-1,850
Cataract Surgery	250		
with Lens Implant	350	2,000	2,600
not including			
prosthesis			
(list separately)			
Septorhinoplasty	400	1,400	2,500

* Levels 1, 2 and 3 are explained later in this article.

Although surgery traditionally has been performed in hospitals and ambulatory surgical facilities, sophisticated medical knowledge and state-of-the-art facilities and equipment have made it medically safe and cost effective for many surgical procedures to be performed in the doctor's office.

Many physicians and most patients are not familiar with office based surgery. It is advantageous to the patient and to the insurance program when surgical procedures that can safely and economically be performed in a properly equipped doctor's office facility are done there. Most benefits programs currently provide uniform compensation for the surgeon's fee, regardless of whether the procedure was performed in a hospital, an ambulatory surgery facility, or in the doctor's office surgical suite. However, many of the plans still do not reimburse the facility charges for office based surgery even though these charges are usually far less than those charged by a hospital or an ambulatory surgical facility.

Since developing and maintaining a high quality office based surgical suite represents a major out-of-pocket expense and added responsibility, most surgeons are understandably continuing to do their surgery in hospitals and in ambulatory surgical facilities because that is where the benefit plans will pay for it. As was demonstrated on the chart, this coverage occurs at a substantially higher cost.

There is a trend toward change. A growing number of leading insurance carriers will now reimburse the charges which represent costs, not profits, made by the surgeon for his facility expense.

COMPENSATION

A uniform approach among carriers to compensate for the office based surgical facility expenses will help ensure that the office based surgical suite does not become a profit center only. The advantage for the surgeon remains in place because it enables him or her to spend more time providing services rather than traveling to another location to perform surgery. Adequate reimbursement will help encourage more surgeons to provide their services in the office setting, and this location will be preferred by many patients.

Carriers who are compensating the surgeon for his office based surgical facility expenses are generally reimbursing that expense at 25% to 30% of the usual, regular, and customary fee for the procedure performed. An allowance on this basis up to a maximum of $400 is plenty. If it needs to be more, perhaps the surgery shouldn't be done in the office. There is very little general anesthesia in the office setting now, so the maximum for levels 1 and 2 should still be around $250.

A separate charge should be itemized for prosthesis, braces, splints, etc., and could be reimbursed at cost plus 10%.

In biopsy cases, we must know if it was an open biopsy or a needle procedure. We also need to know if it was superficial (e.g., thyroid, lymph gland, skin or subcutaneous tissue, etc.) or if it was deep (e.g., muscle, bone, deep gland or internal organ).

Special kinds of office based surgical facilities require special consideration such as cardiac catheterization labs, gastrointestinal labs, urology or neurologic labs, radiology and nuclear medicine testing centers.

ADVANTAGES

The advantages to the surgeon performing surgery in his own office are obvious.

> Patients are spared the higher cost and inconvenience of an overnight stay in a hospital.
>
> Physicians are given the freedom and flexibility of performing the surgical specialties in familiar surroundings with their own personnel and equipment.
>
> The result is a significant savings in the surgeon's time and a convenience for everyone involved.
>
> The concept of office based surgery has resulted in lower cost malpractice insurance for members of the Society For Office Based Surgery than for others, but it is still higher than it was 2 or 3 years ago. This is a significant savings for the surgeon. For the carrier, an advantage exists in that peer review is available through the Society For Office Based Surgery on utilization and quality of care.

ORGANIZATIONS

Two organizations exist which actively endorse the concept of office based surgery.

American Society of Plastic & Reconstructive
Surgeons, Inc. (ASPRS)
233 North Michigan Avenue, Suite 1900
Chicago, Illinois 60601

One purpose of the ASPRS is to provide a better understanding of certain plastic surgery procedures which can be aesthetic and/or reconstructive in purpose. However, plastic surgeons in general have established surgical suites within their offices and have operated in this environment for many years to reduce the expense for their patients when cosmetic procedures are not eligible for insurance reimbursement. As insurers, this should be a lesson on the economic advantages of surgery being done in the physician's office, as opposed to in an ambulatory surgical facility, or particularly to in-hospital surgery.

Society For Office Based Surgery
P.O. Box 33185
San Diego, CA 92103

This organization, whose eligibility for membership is limited to board-certified and board-eligible surgeons and anesthesiologists, was established in 1978. Its purpose was to create a national awareness of the benefits and cost savings offered by office based surgery, set standards for high-quality care and treatment, as well as to provide an educational forum and information source for participating physicians and surgeons. In addition to its original mission, the Society has done much to obtain reimbursement for facilities from insurance carriers, has obtained lower cost malpractice insurance for its members, and has improved accreditation procedures.

ACCREDITATION

Accreditation for office based surgical facilities is available through two organizations.

Accreditation Association for Ambulatory Health Care (AAAHC)
9933 Lawler Avenue
Skokey, Illinois 60077-3702

&

American Association for Accreditation Plastic Surgery Facilities (AAAPSF)
505 East Hawley Street
Mundelein, Illinois 60060

Insurance carriers may wish to require that an office based facility be accredited by the appropriate accreditation agency in order for facility costs to qualify for consideration under the plan. Or, carriers may wish to obtain the specific requirement for accreditation from the above agencies, and establish their own criteria for determining which facilities are approved for reimbursement. At this time, the AAAHC classifies its facilities as follows:

Level 1

ANESTHESIA CAPABILITY - Local anesthesia with light sedation.

EXAMPLES OF APPROPRIATE OPERATION - Myringotomy, with or without tubes, excision of bartholin cysts, superficial biopsy, D&C, deep needle biopsy (liver, lung, kidney).

EQUIPMENT NEEDED - Crash cart, IV sedation, ambu bag, airway tube, O2 tank with valve suction machine, appropriate light.

Level 2

ANESTHESIA CAPABILITY - Local anesthesia with heavy sedation.

EXAMPLES OF APPROPRIATE OPERATION - Septoplasty, cosmetic surgery, mini-lap, tubal ligation, open breast biopsy, open laparoscopy, cataract extraction, treatment of certain fractures.

EQUIPMENT NEEDED - Same as level 1 plus operating table, cardiac monitor, defibrillator, bovie unit.

Level 3

ANESTHESIA CAPABILITY - General anesthesia (same as free-standing surgical center).

EXAMPLES OF APPROPRIATE OPERATION - Hernia repair, hemorrhoidectomy, closed laparoscopy, skin grafting, Moh's chemosurgery, retinoscopy of infants, D&C or pelvic exam in selected cases, reduction of simple fractures.

EQUIPMENT NEEDED - Same as levels 1 and 2 plus anesthesia machine, autoclave.

The AAAPSF accredits their facilities based upon the following class definitions.

Class A

Performed under local, regional, or topical anesthesia; applies to minor plastic surgical procedures.

Class B

Performed under intravenous or parenteral sedation, analgesia or dissociative drugs; applies to minor or major plastic surgical procedures.

Class C

Major plastic surgery procedures performed under general anesthesia with external support of vital body functions.

While room does not permit inclusion of the accreditation criteria in this document, there are similarities between the two accreditation agencies in classifying facilities as Level 1, 2, 3 or Class A, B and C respectively.

Accreditation provides public credibility and a sense of security for patients who choose an office based surgical suite over an ambulatory surgical facility or a hospital. Accreditation occurs through on-site evaluation by professional peers and thereby enables the surgeon to ensure quality of care through this inspection, consultation, and educational advice on how to handle different situations.

Medicare certification of surgical suites is based upon their criteria for ambulatory surgical centers and has not yet been streamlined to include a criteria for the office based surgical suite. Medicare's criteria for certifying ambulatory surgical centers is similar in many respects to the accreditation standards used by the AAABC.

CLAIM CONTROLS

Carriers must control any extra facility costs for office based surgery through claim processing procedures and plan design. Claim examiners must be watchful of office based surgical episodes to consider only those surgeries that are new to the office setting. Surgery that has traditionally been done in a doctor's office does not usually qualify for extra facility benefits because the usual, regular and customary fee for the procedure has already been established and includes any cost for extra equipment and supplies to accomplish the procedure.

CONCLUSION

This document has pointed out the advantages of office based surgery, the agencies that are available to accredit the facilities and help control their utilization. Guidelines for reimbursement of overhead expenses have also been provided.

It is evident that controlled reimbursement of expenses incurred for surgery done in an office based surgical suite can conserve the benefits available on any plan. Ensuring that the surgeon is compensated for the traditional fee plus any valid overhead expenses will encourage more and better office based facilities to be established.

Blue Shield
Ohio Medical Indemnity Mutual Corp. 6740 North High Street/Worthington, Ohio 43085 (614) 438-3500

February 22, 1983

Ms. Cristine E. Clauson
Director, Management and Planning
American Society of Plastic and
Reconstructive Surgeons, Inc.
233 North Michigan Avenue
Suite 1900
Chicago, Illinois 60601

Dear Ms. Clauson:

For some time, this Blue Shield Plan has placed a special emphasis on the development of cost effective programs in the medical care system. Since our Plan serves nearly three million Ohioans, we feel that encouragement of cost effective program experiments and demonstration projects can have a significant impact on the health care practice patterns and charges of Ohio health care providers.

In the review of possible program initiatives, we recalled the proceedings of the AMA National Medical Specialty Society Cost Effectiveness Conference held on May 11 and 12, 1981, in Chicago. We are interested in learning the outcome of the projects which were presented at that conference.

Attached is a description of the project associated with your office as published by the American Medical Association. I would appreciate a brief review of subsequent activity. Was the project undertaken/completed? What was the outcome and what follow up or conclusions were obtained? Was there any activity in this project area in the State of Ohio, to your knowledge? Do you feel the project or results would have applicability to Ohio? Are there persons in Ohio whom you feel we could contact about the project or a replication or extension of the project (names and addresses, please)?

Thank you very much for any information you can send on this. If you wish to call me, my number is (614) 438-3592. I look forward to your reply.

Sincerely,

Lawrence E. McPhee
Senior Consultant
Health Systems

LEM/dd
Enclosure
cc: Neal McCue

COST EFFECTIVENESS OF AMBULATORY PLASTIC SURGERY FACILITIES

By

American Society of Plastic and
Reconstructive Surgeons, Inc.

ABSTRACT: *The American Society of Plastic and Reconstructive Surgeons has developed a comprehensive program for the accreditation of plastic surgery facilities located in a physician's office. The accreditation program provides a quality assurance function essential to encouraging the use of these facilities.*

Objective

The objective of the project is to promote the utilization of peer-inspected and accredited ambulatory plastic surgery facilities to provide a safe and cost effective alternative to more expensive hospital surgical facilities.

Potential for Cost Effectiveness

Outpatient ambulatory surgical treatment has been used effectively and safely for over 25 years, primarily in the area of plastic and reconstructive surgery. The use of outpatient facilities provides better utilization of less expensive space, promotes the most effective use of physician time and energy, and improves the physician-patient relationship by reducing the comparatively impersonal intervention of hospital staff members, who may have little knowledge of the patient, thus reducing liability exposure.

Cost savings of 50 to 90 percent are realized by both patient and insurance carriers through the reduction or elimination of fees in the following areas: patient preparation, surgery, operating suite overhead, per diem recovery, medications, staffing, laboratory and x-ray charges. As the patient is usually ambulatory immediately after surgery, there is seldom need for a hospital stay. Thus hospital beds may be reserved for those who truly need them; and both nursing and ancillary care is reduced, decreasing hospital costs.

A recent independent study on the cost of a combined breast augmentation/abdominoplasty indicates the savings possible.

	Hospital	Office
Surgeon's Fee	Same	Same
Operating Room Charge	$ 900.00	$500.00
Operating Room Supplies	259.00	-0-
Anesthesiologist	615.00	-0-
Anesthesia Supplies	106.00	-0-
Surgical Bra	64.50	8.50
Room and Board (5 days)	650.00	375.00*
TOTAL	$2,594.50	$883.50

(*Licensed Intermediate Care Facility)

Implementation

Implementation of this project would require several steps: (1) An accreditation organization would be created to inspect and accredit ambulatory plastic surgery facilities. This organization would set standards and guidelines for safe and cost effective surgical care, i.e., American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF). (2) Physicians and facility directors would be educated through symposia, internal communications, and distribution of standards, guidelines, and inspectors' manuals (already being implemented by AAAAPSF). (3) Dialogue would be established with third-party carriers and government agencies in concert with supportive actions of the American Medical Association, American Society of Plastic and Reconstructive Surgeons, and the American Association for Accreditation of Ambulatory Plastic Surgery Facilities. (4) Steps would be initiated to obtain the support of the AMA, American College of Surgeons, and other interested parties, to effect legislative changes in Title II, Public Law 95-449, so as to effectively implement the intent of the law and remove bureaucratic and regulatory obstacles in implementing cost effective ambulatory surgery.

The implementation process requires the participation of the individual board-certified physician, a national peer accreditation organization (e.g., the American Association for Accreditation of Ambulatory Plastic Surgery Facilities), and the national medical specialty society (to deal with issues of cost containment and quality control). Such participation will result in a concentrated effort to inform members, the general public, and third-party carriers of the benefits and cost effectiveness of ambulatory surgical care.

The Board of Directors of the American Society of Plastic and Reconstructive Surgeons has approved the establishment of the American Association for Accreditation of Ambulatory Plastic Surgery Facilities. Prior to publication of the project, a finalized description will be presented to the President of the American Society of Plastic and Reconstructive Surgeons and the Society's Socioeconomic Commission Chairman for review. The Society's members will be informed of the project through Plastic Surgery News, national conferences, workshops, educational seminars, medical medic/public relations, and interspecialty society communications [e.g., Council of Medical Specialty Societies, ans Delegates, etc.]

Other specialties [general surgeons, obstetricians/gynecologists, ophthalmologists, urologists, etc.] may also wish to be included in the project.

Possible Barriers to Implementation

The approval and assistance of third-party carriers is important to this project. Although actual costs of ambulatory outpatient surgery are lower than that of hospitals, without the approval of accredited facilities by insurance carriers, significant overall national cost effectiveness will not be achieved. This would require changes in the terms of third-party carrier reimbursement, especially Blue Cross, Aetna, and Medicare. Also, unreasonable and non-pragmatic government regulations and lack of cooperation between government agencies and third-party carriers and the AAAAPSF would have a detrimental effect on the project's success.

Evaluation

The following key indicators would show physicians that the project has achieved its objectives:

- The accreditation of a physician's ambulatory plastic surgery facility by the AAAAPSF.
- Construction of more efficient, cost effective ambulatory plastic surgery facilities.
- Third-party carrier approval and reimbursement of accredited ambulatory plastic surgery facilities.
- Reduction of cost per surgical illness to third-party carriers.
- Reduction of cost to disability insurance carriers and disability portions of workman's compensation insurance carriers.
- Availability of comparative statistics of costs per surgical illness of patients in the hospital versus patients in ambulatory plastic surgery facilities.
- Better utilization of physician's time will be indicated by greater availability of time to treat more patients, keep abreast of advancing medical technology, enhancement of the physician-patient relationship, and a decrease in the surgeon's tension and stress.

Physicians would provide a written evaluation of their participation in the project. A peer inspector would evaluate the process. Questionnaires and surveys would be mailed to those physicians who participate in the inspection and the accreditation process.

For further information regarding this
project, contact:

Ms. Cristine E. Clauson
Director, Management and Planning
American Society of Plastic and
Reconstructive Surgeons, Inc.
233 North Michigan Avenue
Suite 1900
Chicago, Illinois 60601
(312) 856-1818

Blue Cross
Blue Shield
of Maryland

700 East Joppa Road, Baltimore, Maryland 21204

April 12, 1989

Stanley A. Klatsky, M.D., P.A.
122 Slade Avenue
Baltimore, Maryland 21208

Dear Dr. Klatsky:

Blue Cross-Blue Shield of Maryland, Inc. (BCBSM) has revised its participating provider standards for ambulatory surgical centers (ASCs). The revised standards have been developed to encourage utilization of freestanding ASCs by BCBSM subscribers. ASCs meeting these standards will qualify for a facility fee payment from BCBSM, in addition to the professional fee allowed for the operating surgeon.

BCBSM reimbursement for the facility fee will be similar to the recently proposed Medicare model of payment. Six payment categories have been developed. The Medicare list of approved procedures and the category groupings form the basis of our list. Local practice has been used in minor modifications to procedures covered under our program. The completed list of procedures will be available soon. Reimbursement will be made based on the payment category into which the surgical procedure appropriately falls. It should be noted that on average, the BCBSM facility fee payment structure provides a higher level of reimbursement than Medicare.

As you have previously indicated an interest in developing a participating provider agreement with BCBSM as an ASC, we are sending you the following materials:

1. A list of the BCBSM standards for participating ASCs.

2. A list of the documentation that we require for our review.

3. A sample copy of the participating provider agreement utilized by BCBSM for freestanding ASCs.

4. A list of the BCBSM allowed facility fees.

Please review these materials. If you are interested in developing a participating provider agreement with BCBSM as a freestanding ASC, and you can meet all of the standards, please have the required documentation put together for our review. We would be most happy to schedule a time for you to come in and meet with us to review the documentation and answer any questions that you may have. If you prefer, you may submit the documentation via the mails. We will notify you of any questions we may have with the documentation.

Stanley A. Klatsky, M.D., P.A.
Page 2
April 12, 1989

If you have any questions, please call me at 494-5017 or Bob Roys at 494-5072.

Sincerely,

James M. Doty
Coordinator
Institutional Contracting
and Reimbursement

ew/6787

Enclosures

Blue Cross
Blue Shield
of Maryland

700 East Joppa Road, Baltimore, Maryland 21204

STANDARDS FOR THE RECOGNITION AS AN APPROVED FREESTANDING AMBULATORY SURGERY CENTER

INTRODUCTION

Blue Cross and Blue Shield of Maryland, Inc. (BCBSM) exists to provide our community with dependable and reasonably priced protection against the cost of health care. To fulfill our purpose, Blue Cross and Blue Shield of Maryland will recognize a freestanding ambulatory surgery center (ASC-hereinafter called facility) when it provides a covered service economically, without causing duplication or inefficient use of existing facilities or services. A freestanding ambulatory surgery center is defined as a public or private organization, (not regulated by the Maryland Health Services Cost Review Commission) and not a private physician's office or group practice, which has permanent facilities and equipment for the provision of surgery under general and local anesthesia on an outpatient basis, and not requiring overnight stays, by qualified physicians, dentists and podiatrists of an organized medical and nursing staff. Our basic requirements for Blue Cross and Blue Shield recognition follow.

I. Licensing and Approval

  A. The facility must only render services or operate facilities or equipment which may have been issued a Certificate of Need (CON), if required, by the Maryland Health Planning Resources Commission.

  B. The facility must meet the requirements of the state and any subdivision in which it is located, pursuant to licensing and other approvals where appropriate and/or required by law.

  C. The facility must be recognized by Medicare as a qualified, participating ambulatory surgery center as of the date the facility contracts with BCBSM.

  D. The facility must be accredited by one of the following organizations within one year of the date the facility contracts with BCBSM:

    1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO),

    2. Accreditation Association for Ambulatory Health Care, Inc. (AAAHC),

    3. American Association for Accreditation of Ambulatory Plastic Surgery (AAAAPSF-facility must be classified as class B or C).

E. If the facility ceases to participate in the Medicare program, or has its accreditation revoked, the contract between the parties shall become null and void as of the effective date of the departicipation or revocation. If the facility fails to become accredited within the one year period specified in I.D., except as noted in I.F., the contract between the parties shall become null and void on the first day following the close of that year.

F. An exception to the one-year rule specified in I.D. will be made if, and only if, the facility can document that the failure to become accredited was beyond its control. Events that are beyond the facility's control include delays by the accrediting body in surveying the facility or granting accreditation for reasons other than those that are related to the facility's compliance with the accreditation organization's standards. An example of such an event would be the inability of the accrediting body to conduct a survey in an timely manner due to a backlog of applications.

G. The facility's status with respect to accreditation will be determined by reference to the accrediting body.

II. Ownership and Control

A. The facility shall disclose its ownership. If a corporation, the corporate officers shall be made known; if a public agency, the governing body shall be disclosed. If a partnership, all partners (full, limited, etc.) must be disclosed. Additionally, all organizations related to the facility through ownership or control, supplying goods or services to the provider must be disclosed.

B. Change in ownership or control must be reported to BCBSM within 30 days of the date of the change.

III. Administration

A. There shall be an identifiable governing authority legally responsible for the conduct of the institution and accountable to the community.

B. There shall be a chief executive to whom the governing authority delegates responsibility for the day-to-day operation of the institution in accordance with established policy.

C. The organization either has a written transfer agreement for transferring patients to a nearby hospital when hospitalization is indicated, or grants privileges only to practitioners who have admitting and similar privileges at nearby hospitals.

IV. Medical and Other Professional Staff

A. There shall be an organized Medical Staff comprised of professionals licensed to perform surgery in the State of Maryland, to which the governing authorities delegate responsibility for maintaining proper standards of medical care. This staff of professionals shall be competent to perform the procedures they undertake.

B. All members of the Medical Staff shall be granted specific privileges which are consistent with their education, experience, and specialty designation (board eligibility and/or certification or membership in National Specialty Society).

C. Each patient shall be admitted in the authority of a member of the Medical Staff who shall be directly responsible for patient's diagnosis and treatment.

D. Other professional staff shall be licensed in their specialty as required by law and/or certified by appropriate professional organizations. These professionals shall be competent to perform the procedures they undertake.

V. Operations

A. The facility will be operated for the purpose of providing approved designated health care services. No inpatient beds for overnight care of patients will be maintained. It will not routinely provide provide emergency care but will be prepared to handle emergencies that develop among its own patients.

B. The facility shall be appropriately structured, equipped, staffed and maintained for the type of care rendered. All services shall be available during the regularly scheduled hours.

C. Registered professional nursing supervision and other nursing services shall be continuous during the regular scheduled hours.

D. The facility shall maintain organized medical records that reflect data appropriate to the treatment rendered for each patient. Such records shall contain sufficient information to clearly identify the patient, support the diagnosis and treatment and records the results. The facility shall keep these records confidential and protected from unauthorized use.

E. The facility must maintain adequate malpractice and liability insurance to safeguard its operations.

VI. Medical Care Appraisal

A. The facility will establish and maintain an active medical review program. A Tissue Committee will be established to review surgical procedures performed in the facility.

B. A Utilization Review Committee, conforming to acceptable medical standards in the community, shall have the responsibility to assist in affecting proper utilization of the services in the facility. Physicians serving on this committee who have a financial interest in the facility shall not be professionally involved in the review of their own cases.

VII. Fiscal Management

A. The facility shall demonstrate that it maintains accurate and current financial, statistical and business records according to accepted accounting practices in order to assure financial viability.

VIII. Billing and Payment

A. The facility shall not bill BCBSM's subscribers for "non-approved" procedures; i.e., procedures that are not eligible for a facility fee and that are not on the list of approved procedures published by BCBSM. The facility may bill the subscriber for "non-covered" procedures and/or services; i.e., services and/or procedures that are excluded as a benefit in the subscriber's health insurance contract. Examples of non-covered procedures and services include "cosmetic" surgery and prosthetic devices.

B. Except as provided for in VIII. C., the facility shall agree to accept BCBSM's reimbursement as payment in full for approved services.

C. Charges made to subscribers for deductibles, coinsurance and non-covered services (e.g., prosthetics) provided to a subscriber during the performance of an approved procedure, when taken together with the amount paid or payable by BCBSM, shall not exceed the amount that BCBSM would pay in the absence of deductibles, coinsurance and non-covered services.

IX. Program Evaluation

A. The facility shall conduct periodic and regular review and evaluation of its programs and policies to assure quality and cost effective care is rendered.

These standards for the recognition as an approved freestanding ambulatory surgical facility serve as a guide to Blue Cross and Blue Shield. Blue Cross and Blue Shield of Maryland reserves the right to make final interpretation and determination of provider compliance.

Blue Cross
Blue Shield
of Maryland

700 East Joppa Road, Baltimore, Maryland 21204

DOCUMENTATION FOR APPROVAL
FREESTANDING AMBULATORY SURGERY CENTERS

Facilities wishing to obtain approved status with Blue Cross and Blue Shield of Maryland should submit the following documentation to Jim Doty at Blue Cross and Blue Shield of Maryland, Institutional Contracting and Reimbursement, 700 East Joppa Road, Baltimore, Maryland 21204, (301-494-5017)

1. Copy of By-laws and regulations governing Medical and/or Professional Staff.
2. Name of Administrator, Assistant Administrator, Medical Director, Chief Financial Officer and other key administrative personnel, as appropriate. Organizational chart.
3. Roster of physicians having facility privileges, indicating professional disciplines.
4. Evidence that the facility is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC) or the American Association for Accreditation of Ambulatory Plastic Surgery (AAAAPSF). If the facility is not accredited, the following information/documentation must be submitted:
    a. date facility opened,
    b. copy of application for accreditation or the name of the accrediting body to which application will be made and the approximate date the application will be submitted.
    c. the actual or scheduled date of the accrediting body's survey if application has been made.
5. Evidence that the facility is qualified to participate in the Medicare program.
6. A copy of the facility's Certificate of Need or evidence that the facility is exempt from the rules and regulations governing Certificate of Need for freestanding ASC's.
7. Copy of utilization review protocol.
8. Copy of the patient transfer agreement(s) between the facility and one or more hospitals.

9. The facility's Chart of Accounts, budget for the current fiscal period and a copy of the audited financial statements for the most recent fiscal year. If the audited financial statements pertain to a fiscal year that ended more than three months prior to the submission of them, the facility must also submit financial statements for the most recent quarter for which such statements are available. Newly organized facilities are responsible for providing a Chart of Accounts and a budget; audited financial statements must be submitted as soon as they become available.

10. Itemized schedule of facility charges.

11. Name, address and telephone number of the facility's certified public accountant.

12. Indication of fiscal year.

13. Tax identification number and, if non-profit, exemption.

Blue Cross
Blue Shield
of Maryland

700 East Joppa Road, Baltimore, Maryland 21204

AMBULATORY SURGERY CENTERS

Allowed Facility Fees
Effective April 1, 1989

Payment Group	Allowed Fee
1	$265
2	335
3	450
4	485
5	595
6	665

Payment for intraocular lenses will be made at the rate of $300 per lens. This payment is an "add-on" to the appropriate payment group fee for the cataract procedure requiring an IOL insertion. The add-on is applicable to the following procedures only:

CPT-4 Code	Payment Group	Maximum Fee
66983	6	$965
66984	6	965
66985	4	785

8814

Blue Cross
Blue Shield
of Maryland

700 East Joppa Road, Baltimore, Maryland 21204

SAMPLE

AMBULATORY SURGERY CENTER

HEALTH CARE PROVIDER AGREEMENT

Blue Cross & Blue Shield of Maryland, Inc. (BCBSM) and ______________ ______________ (Provider) agree as follows:

1. That the Provider will render covered services to eligible members of BCBSM, any other Blue Cross and/or Blue Shield Plan, and any BCBSM subsidiary, in accordance with the type of coverage program held by the member.

2. That the Provider will bill BCBSM or the applicable subsidiary for covered services under its subscription agreements and contracts in effect and approved by the Insurance Commissioner of the State of Maryland.

3. That BCBSM or subsidiary will reimburse the Provider according to the terms of its members' subscription agreement based on a payment arrangement as defined in Exhibit A attached hereto.

4. That the Provider may collect from BCBSM members or subsidiary members only those amounts due for covered services as may be payable by the member or subsidiary pursuant to the terms of the subscription agreements and contracts in effect for such coverage. This obligation shall survive the termination of this agreement as to any services provided while this agreement is in effect.

5. That the Provider will allow BCBSM's qualified representatives on behalf of itself or any of its subsidiaries to review the appropriate records in the interest of assuring that all care rendered was properly ordered and signed for by a physician or other licensed professional as required by law. The Provider agrees that neither BCBSM nor applicable subsidiary will not reimburse Provider for services not properly documented as defined above and the member will not be billed for these services.

6. That the Provider will allow BCBSM's or applicable subsidiary's qualified representatives to review the appropriate medical records for the purpose of assuring that the services rendered were medically necessary and were billed properly The Provider agrees not to bill the BCBSM member or subsidiary member for care determined by BCBSM or the subsidiary to be medically unnecessary in accordance with policies and procedures of their utilization control and admissions review programs.

7. The Provider agrees to abide by the standards and criteria for recognition as an approved provider of Blue Cross and Blue Shield of Maryland and/or applicable subsidiary.

8. The Provider agrees to file with BCBSM and/or subsidiary, a copy of the Provider's audited financial statements for the fiscal year preceding the effective date of this agreement and for each subsequent fiscal year this agreement is in effect. The Provider further agrees to provide BCBSM or applicable subsidiary, on request, with a schedule of the Provider's established charges for covered services.

9. That this agreement insofar as it pertains to them shall be subject to cancellation by any of the parties upon 60 days written notice to the others, but such cancellations shall not affect the obligations of BCBSM, its subsidiaries, or the Provider with respect to patients in the facility at the time such termination becomes effective, nor shall such termination affect mutual obligations of the parties hereto incurred on the date of termination.

10. That this agreement shall be effective ____________________.

AGREED TO:

BLUE CROSS AND BLUE SHIELD
OF MARYLAND, INC.

BY: ____________________
(Arthur T. Keefe, M.D.)

TITLE: Vice President and
Corporate Medical Director

DATE: ____________________

____
____

BY: ____________________

TITLE: ____________________

DATE: ____________________

EXHIBIT A

Blue Cross and Blue Shield of Maryland, Inc. and its Subsidiaries (BCBSM) will reimburse ______________________________ (Provider) for covered services based on the following regulations and schedules:

I. Approved and Non-Approved Procedures

A. Definitions

1. Approved procedures - a procedure for which BCBSM will pay the facility a fee according to the provisions of Parts III and IV of this exhibit.

2. Non-approved procedure - a procedure for which no facility fee will be paid.

B. Approved Procedures

1. The procedures approved for reimbursement by BCBSM consist of procedures approved for provider reimbursement by Medicare with certain modifications.

Appendix I of this exhibit lists the approved procedures.

2. Modifications, including additions and deletions will be made from time-to-time to Appendix I. These modifications will reflect actions taken by a continuing assessment by BCBSM of the appropriateness of the current list of approved procedures.

3. BCBSM will give providers 60 days advance notice of deletions from the list of approved procedures.

C. Non-approved Procedures

1. The provider shall not bill nor hold liable BCBSM's members for non-approved procedures; i.e., procedures that are not on the list of approved procedures (Appendix I of this exhibit).

2. In the event that the provider performs a procedure that is both non-approved and non-covered, the provisions of Part II. B. 1. of this exhibit shall apply.

II. Covered and Non-Covered Services

A. Definitions

1. Covered service - an approved procedure or a service rendered to or on behalf of a BCBSM member that is defined as a health care benefit in the contract between BCBSM and the member.

2. Non-covered service - a procedure or a service rendered to or on behalf of a BCBSM member that is excluded as a health care benefit in the contract between BCBSM and the member.

B. Liability for Non-covered Services

1. The liability for a non-covered procedure and related services rests with the member. Billing and payment terms are a matter between the member and the provider.

2. In the event the provider provides a non-covered service to a member in conjunction with the performance of an approved procedure, the liability for the non-covered service rests with the patient. However, the member's liability shall be limited as provided in Part III. C. of this exhibit.

III. Payment Provisions

A. The amount paid by BCBSM to the facility shall be the allowed facility fee for the procedure performed or actual charges, whichever is less.

B. Member's liability for any deductibles and/or coinsurance shall be calculated based on the allowed facility fee for the procedure performed or actual charges, whichever is less.

C. The member's liability to the provider for deductibles, coinsurance and non-covered services provided in conjunction with the performance of an approved procedure together with BCBSM's liability shall not exceed the allowed facility fee for the procedures performed or actual charges, whichever is less.

D. The allowed facility fee provides for the payment of all services associated with the performance of approved procedures including:

- operating and recovery room,
- anesthesia supplies,
- medical and surgical supplies (including prosthesis)
- drugs
- professional and technical fees for
  - laboratory/pathology
  - radiology
  - cardiology

Services of the operating physician, Anesthesiologists and Certified Registered Nurse Anesthetists (CRNA's) are not included in the allowed facility fee.

IV. Allowed Facility Fees

A. Each approved procedure is assigned to one of six payment groups, each of which has a discrete allowed facility fee. The payment group to which an approved procedure is assigned is designated on Appendix I. The allowed facility fee for each group is contained on Appendix II of this Exhibit.

B. The allowed facility fee for each of the payment groups represents the maximum liability of BCBSM and the member; i.e., there shall be no additional liability if two or more procedures are performed on the member.

C. The allowed facility fees contained on Appendix II shall be reviewed annually, more or less, for appropriateness. Provider's shall be given 60 days notice of modifications to Appendix II.

V. Effective Dates of the Exhibit A

The schedule of approved procedures (Appendix I) and the allowed facility fees (Appendix II) shall be made effective April 1, 1989. These schedules shall remain in effect until they are modified by BCBSM with due notice as required under Parts I. B. 3. and IV. C.

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"(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

"(E) has a requirement that every patient must be under the care of a physician;

"(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard established for such licensing;

"(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

"(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

"(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.".

(f) Section 1863 of such Act is amended by striking out "and (a)(6)" in the first sentence and inserting in lieu thereof "(a)(6), and (cc)(2)(I)".

(g) Section 1864(a) of such Act is amended—

(1) by inserting "or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2)" after "section 1861(aa)(2)" in the first sentence; and

(2) by inserting "comprehensive outpatient rehabilitation facility," after "rural health clinic," each place it appears in the second and fifth sentences.

(h) The amendments made by this section shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after July 1, 1981.

OUTPATIENT SURGERY

Sec. 934. (a) Section 1832(a)(2) of the Social Security Act is amended by adding after subparagraph (E) (added by section 933(a) of this title) the following new subparagraph:

"(F) facility services furnished in connection with surgical procedures specified by the Secretary—

"(i) pursuant to section 1833(i)(1)(A) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations) if the center has an agreement in effect with the Secretary by which the center agrees to accept the amount determined under section 1833(i)(2)(A) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all such services furnished by the center to individuals enrolled under this part, or

"(ii) pursuant to section 1833(i)(1)(B) and performed by a physician, described in section 1861(r)(1), in his office, if the Secretary has determined that—

"(I) a Professional Standards Review Organization (designated, conditionally or otherwise, under part B of title XI of this Act) is willing, able, and has agreed to carry out a review (on a sample or other reasonable basis) of the physician's performing such procedures in the physician's office,

"(II) the particular physician involved has agreed to make available to such Organization such records as the Secretary determines to be necessary to carry out the review, and

"(III) the physician is authorized to perform the procedure in a hospital located in the area in which the office is located,

and if the physician agrees to accept the amount determined under section 1833(i)(2)(B) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with such surgical procedure to individuals enrolled under this part.".

(b) Section 1833 of such Act is amended by adding at the end the following new subsection:

"(i)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations—

"(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1832(a)(2)(F)(i)) or hospital outpatient department, and

"(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

"(2)(A) The amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

"(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure, and

"(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title *than would have been paid if the procedure had been performed on an inpatient basis in a hospital.*

Each amount so established shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

"(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

"(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

"(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

"(3) In the case of services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in a physician's office, an ambulatory surgical center described in such paragraph, or a hospital outpatient department, payment for such services shall be determined in accordance with subsection (a)(1)(G) if the physician accepts an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for such services.

"(4)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

"(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.".

(c)(1) Section 1863 of the Social Security Act is amended by inserting "or by ambulatory surgical centers under section 1832(a)(2)(F)(i)," after "section 1861,".

(2) Section 1864(a) of such Act is amended—

(A) by inserting before the period at the end of the first sentence the following: ", or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i)"; and

(B) by inserting "ambulatory surgical center," in the fifth sentence after "health care facility," each place it appears.

(d)(1) Section 1833(a)(1) of such Act, as amended by section 933(a)(1) of this title, is further amended by inserting after the comma at the end of clause (F) the following new clause: "and (G) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services,".

(2) For an additional amendment to section 1833(a) of the Social Security Act with respect to the amount of payment for outpatient surgical procedures, see section 942 of this title.

(3) The first sentence of section 1833(b) of such Act, as amended by section 930(h) of this title, is further amended by adding before the period at the end the following: ", and (4) such total amount shall not include expenses incurred for services the amout of payment for which is determined under subsection (a)(1)(G) or under subsection (i)(2) or (i)(4)".

OUTPATIENT PHYSICAL THERAPY SERVICES

SEC. 935. (a) Section 1833(g) of the Social Security Act is amended by striking out "$100" and inserting in lieu thereof "$500".

(b) The amendment made by subsection (a) shall apply to expenses incurred in calendar years beginning with calendar year 1982.

DENTISTS' SERVICES

SEC. 936. (a) Clause (2) of the first sentence of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,".

(b) Section 1814(a)(2)(E) of such Act is amended to read as follows:

"(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, require hospitalization in connection with the provision of such services; or".

(c) Section 1862(a)(12) of such Act is amended by inserting "or because of the severity of the dental procedure," after "clinical status".

(d) The amendments made by this section shall apply with respect to services provided on or after July 1, 1981.

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Commissioner, Department of Public Health, State of Massachusetts, Boston; and Colonel Thomas L. Pitchford, M.S.C., U.S.A., (1982), Radiological Hygiene Consultant, U.S. Army Health Services Command, Fort Sam Houston, San Antonio, TX.

Since its inception in 1968, TEPRSSC has provided valuable technical and scientific advice to the Bureau of Radiological Health, FDA, on the development of electronic product radiation safety performance standards. Thus far, regulatory performance standards have been issued under 21 CFR Chapter I, Subchapter J, for television receivers, cold cathode gas discharge tubes, microwave ovens, diagnostic x-ray systems and their major components, cabinet x-ray equipment (including x-ray baggage inspection devices for use at airports and similar facilities), laser products, sunlamp products (for skin-tanning purposes), high-intensity mercury vapor discharge lamps, and ultrasound therapy equipment. The Committee meets approximately once each year and occasionally also reviews documents transmitted by mail.

Under section 358(f) of the Radiation Control for Health and Safety Act of 1968, members will be appointed by the Commissioner after consultation with public and private agencies concerned with the technical aspect of electronic product radiation safety. Each member shall be technically qualified by training and experience in one or more fields of science or engineering applicable to electronic product radiation safety. As required by that act, the Committee is composed of 15 members selected as follows:

1. Five from governmental agencies, including State and Federal governments;
2. Five from the affected industry, after consultation with industry representatives; and
3. Five from the general public, one of which shall be a representative of organized labor. The representative of organized labor also must be technically qualified by education or experience in one or more fields of electronic product radiation safety.

Effective December 31, 1981, two members from industry, two members from the public sector, and one member from the governmental sector will complete their terms. In addition, one member from the governmental sector is planning to retire from the military, and will assume a position at a university. This individual also will be replaced.

Nominations are solicited of individuals qualified in electronic product radiation safety to fill these vacancies for a 4-year term. Nominations are invited from labor, industry, public, consumer, government, trade, and professional organizations, and should be submitted with accompanying curriculum vitae and other pertinent information.

Dated: May 13, 1981.

William F. Randolph,

Acting Associate Commissioner for Regulatory Affairs.

[FR Doc. 81-[illegible] Filed [illegible]]

BILLING CODE [illegible]

Health Care Financing Administration

Medicare Program; Ambulatory Surgical Centers

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice and request for comment.

SUMMARY: HCFA is seeking specific information and suggestions for coverage and reimbursement under Medicare of certain surgical procedures that may be performed in ambulatory surgical centers. The information is needed to assist in the development of policies necessary to implement section 934 of the Omnibus Reconciliation Act (Pub. L. 96–499, December 5, 1980). That section, in part, provides new authority for payment under Medicare for procedures performed in these centers.

DATE: To assure consideration, comments should be received by June 22, 1981.

ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration, P.O. Box 17073, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 789, East High Rise Building, 6401 Security Boulevard, Baltimore, Maryland, 21235.

In commenting, please refer to BPP-135–GN. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309–G of the Department's office at 200 Independence Ave., S.W., Washington, D.C., 20201 on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202–245–7890).

FOR FURTHER INFORMATION CONTACT:

Donald Young, M.D. (Coverage) 301–594–[illegible];

Bernard Truffer (Reimbursement) 301–597–1388.

SUPPLEMENTARY INFORMATION:

Background

When reimbursement is made for surgical procedures performed in a hospital setting, whether furnished on an inpatient or outpatient basis, Medicare law currently permits hospital facility costs to be paid for in accordance with Medicare reasonable cost principles. The physician's professional services are reimbursed at 80 percent of the reasonable charge. However, Medicare law limits reimbursement for surgical procedures performed outside the hospital setting; that is, those performed in ambulatory surgical centers (ASCs) not affiliated with a hospital, or in physicians' offices. Coverage and reimbursement for services provided by the facility or the additional costs a physician incurs in staffing and maintaining an area appropriate for surgical procedures has not been permitted. Medicare, of course, pays 80 percent of the reasonable charge for physicians' services in these settings.

This limited reimbursement sometimes has resulted in patients being admitted to hospitals for surgery which may have been performed safely and less expensively in these other settings. A demonstration project conducted by HCFA indicated that (based on a proportional mix of surgical procedures performed in both ASCs and hospitals) the costs for surgical procedures performed in an ambulatory surgical setting were 58.3 percent less than when the procedures were performed on an inpatient basis and 16 percent less than when performed in a hospital outpatient setting.

Section 934 of the Omnibus Reconciliation Act (Pub. L. 96–499) amends Medicare law by authorizing reimbursement for services provided by ASCs when a particular procedure is performed and by increasing reimbursement for physicians' professional services in some cases. The legislation also provides reimbursement for staffing and other costs for surgical procedures performed in physicians' offices; however, this notice does not address that part of the provision. We will consider that portion separately at a later date.

Legislation

Coverage. Section 934 amended section 1832(a)(2) of the Social Security Act to authorize Medicare coverage for facility services furnished in connection with certain surgical procedures performed in an ASC. The Secretary of

Health and Human Services must develop, in consultation with the National Professional Standards Review Council and national medical organizations, a list of those procedures that may be covered under this provision. The procedures on the list would be only those which are often performed on an inpatient basis but which can, consistent with accepted medical practice, be done on an outpatient basis in an ambulatory surgical facility. (We recognize, of course, that for individuals with certain medical conditions a procedure on the list may be safely performed only on an inpatient basis. In those cases we will pay for the surgery on an inpatient basis in the usual way.)

However, the list would not include procedures that have customarily been performed on an outpatient basis in locations that have less elaborate surgical facilities than those found in ambulatory surgical centers; for example, physicians' offices. Congress emphasized that services covered under this provision should be furnished where they can be done appropriately, safely, and less expensively.

Reimbursement. Section 934 of Pub. L. 96-499 distinguishes between payment for facility services furnished by an ASC and payment for physicians' professional services. For facility services furnished by an ASC in connection with a covered surgical procedure, Medicare will pay a prospectively determined overhead rate for each procedure that takes into account the costs incurred by ASCs generally in providing such services, and assure that the payment is substantially less than would have been paid had the procedure been performed on an inpatient basis in a hospital. The overhead amount may be adjusted by the secretary to take account of varying conditions such as geographic locality. The ASC must accept assignment of all Medicare claims; that is, accept Medicare's reimbursement as payment in full for services, as a condition of payment under this provision. Medicare payment will then be made at 100 percent of the overhead rate per procedure. For physicians' professional services, Medicare will pay 100 percent of the reasonable charge for a surgical procedure if the physician performing the procedure accepts assignment of the claim. If assignment is not accepted, the usual rules governing Medicare payments to the physician would prevail.

Request for Information

As indicated by the discussion above, this provision of the legislation grants the Secretary considerable flexibility regarding the types of surgical procedures that may be covered when performed in ASCs, and the rates that may be paid to ASCs for providing services in connection with those procedures. Because of this flexibility, we are requesting information and suggestions from interested persons or groups, professional organizations, specialty societies and surgical facilities to assist us in formulating appropriate policy that is both consistent with the intent of Congress and responsive to the concerns of the public and the health care facilities and practitioners involved.

With respect to the development of lists of covered surgical procedures, we would appreciate information and suggestions on the following:

1. Broad, generally accepted criteria for determining what surgical procedures, now done on an inpatient basis, may be safely performed in ambulatory surgical facilities.

2. Broad, generally accepted criteria for distinguishing those surgical procedures which may be performed in ASCs from those which may be performed in less elaborate surgical facilities.

3. Facility characteristics or capabilities necessary to perform such surgical procedures safely in an ambulatory surgical center (for example, full-scale operating room, recovery room, infection control).

4. Professional services necessary to perform such procedures safely in ambulatory surgical facilities (for example, anesthesia services, nursing services).

5. Specific surgical procedures now done on an inpatient basis which can safely be done in an ambulatory surgical facility.

In developing rates of payment to ASCs for covered surgical procedures, we would appreciate information and suggestions on the following:

1. Services that are included in an ASC's usual charge for a particular procedure. What services, if any, are billed at additional charges?

2. The most feasible mechanism to relate costs incurred by a facility to a particular procedure. Would operating room time, facility charges, or some other mechanism be appropriate for this purpose?

3. Provisions that are made for anesthesia. Is anesthesia provided by facility staff (anesthesiologist or nonphysician anesthetists) or under arrangements? How are such services billed? Are payments made by the facility to an anesthesiologist for "stand-by" coverage?

4. The manner in which third-party payors reimburse the ASC for facility services.

We also encourage ambulatory surgical facilities to submit copies of charge schedules and cost information (income and expense statements, tax returns or other documentation). We would like to use this information as background data in developing reimbursement rates because this provision of the legislation does not explicitly require an ongoing audit of individual financial records. In fact, the legislation amended section 1833 of the Social Security Act to provide that reimbursement should be on the basis of the Secretary's estimate of a fair fee which takes into account the costs incurred by such centers generally. Therefore, in considering how to estimate a fair cost-related fee for surgical overhead costs, we are seeking reliable cost information from potential participants.

We are allowing 30 days for response and will consider all comments in formulating our policy. We plan to issue regulations for implementing section 934 of the legislation as promptly as possible.

Dated: May 13, 1981.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

[FR Doc. 81-[illegible] Filed 5-21-81; 8:45 am]

BILLING CODE 4110-35-M

National Institutes of Health

Advisory Committee to the Director, National Institutes of Health; Meeting

Pursuant to Pub. L. 92-463, notice is hereby given of the meeting of the Advisory Committee to the Director, NIH, on June 8-9, 1981, at the National Institutes of Health, Bethesda, Maryland. The meeting will take place from 8:30 a.m. to 5:30 p.m. on June 8, and from 8:30 a.m. to 12:30 p.m. on June 9, in Building 31, Conference Room 10, C Wing. The entire meeting will be open to the public.

The meeting will be devoted to an examination of (1) costs of biomedical research, and (2) cooperative research relationships among Government, industry, and universities. The Committee has been examining these issues in meetings held over the past several months. Two working groups under the aegis of the Advisory Committee have been established to assist the Committee. In the area of biomedical research costs, presentations will be made on Federal procurement

THE OFFICE SURGICAL FACILITY:
REFUGE FOR THE UNQUALIFIED PHYSICIAN

Presented by

Gustavo A. Colon, MD

Vice President
American Association for Accreditation of
Ambulatory Plastic Surgery Facilities, Inc.

June 28, 1989

Subcommittee on Regulation, Business Opportunities and Energy
Committee on Small Business
U.S. House of Representatives

INTRODUCTION

The number of surgeries performed in ambulatory outpatient facilities has increased significantly in the past ten years. Plastic surgeons are concerned that the proliferation of unregulated office surgical facilities poses a significant danger to the public, not only because of the substandard conditions of many operating facilities but also because these operating units are often owned and staffed by unqualified physicians with little regard for even minimum standards of patient safety.

Today, we see three basic types of facilities falling into the general category of ambulatory outpatient facilities. The first is a hospital outpatient facility, attached to the hospital operating rooms with a separate recovery area. The free-standing surgical facility, as the name implies, is separate from the hospital and is not designed to accommodate overnight care or longterm recovery. This type of facility typically administers to all surgical specialties. The office surgical facility is similar to the free-standing type except it is attached to the office of a surgeon and usually is a single specialty facility.

The major reason for the tremendous rise in ambulatory surgery over the last decade is cost containment. Consumers want, and need, less expensive and more convenient health care options -- provided that quality of care can be maintained. This, of course, is the problem. We find that the greatest danger to patients who elect to have surgery performed in an ambulatory facility is not inherent in the operative procedure itself; it is, instead, the possibility of having selected a physician who lacks proper training, certification and peer review. With a disregard for ethics, safety and responsibility, such unqualified physicians are likely to have inappropriate facilities, equipment, and staff -- all of which further jeopardizes patient welfare and the final surgical outcome.

CASE STUDIES

It is not difficult to find examples of physicians who have created office surgical facilities in order to perform procedures for which they cannot obtain privileges through a hospital. These doctors choose to sidestep the hospital peer review process because they know that their training does not legitimately equip them to perform such procedures. We also see situations in which physicians who have office facilities designed for surgery in a particular specialty will use these facilities to perform procedures for which they have no training. One example is a Houston physician who advertised as a specialist in liposuction and cosmetic surgery, performing these procedures in an office facility that was actually designed as a birthing center. The tragic deaths of two patients undergoing liposuction in this clinic made news throughout the country.

Advertising is one important way in which such unqualified doctors manage to build high volume practices. One New York physician, trained in plastic surgery but not board-certified, conducted a very aggressive, and deceptive, advertising campaign to build his cosmetic surgery practice. He subsequently served a jail sentence for his offenses, with 212 malpractice suits pending against him. Using an uninspected surgical facility and a grossly unqualified staff, this doctor's only apparent concern was how many patients could be run through his cosmetic surgery "mill." The tragic results of his greed were borne by many of his unsuspecting patients.

Another actual case which illustrates our point is the physician who apparently changes office shingles weekly, depending on his current advertising. One week, he identifies himself as a colon-rectal surgeon, the next week a cosmetic surgeon. Imagine the surprise, and dismay, of the cosmetic surgery patient who was having problems and showed up at this doctor's office on the wrong week. This patient understood too late the consequences of selecting the wrong physician. She is currently seeking treatment from a board-certified plastic surgeon to try and correct her botched surgeries; unfortunately, both physical and psychological scars will remain.

Many doctors like the ones described above lure patients to their offices through deceptive advertising, often reciting a long list of official-sounding credentials from so-called "plastic surgery societies." These doctors perform surgeries in their own facilities, totally unexamined by any peer review or accrediting mechanism, without appropriate medical training and with no regard for safe and proper patient selection criteria.

HISTORICAL PERSPECTIVE

Charlatanism and entrepreneurship in plastic surgery is not a new phenomenon, with roots in the early 20th century and especially flourishing in the 1920's and 30's. Dr. Morris Fishbein, who was editor of the Journal of the American Medical Association, wrote a book in 1927 examining quackery and the "cult of beauty." In this book, entitled The New Medical Follies, Fishbein states that "the records of these so-called plastic surgeons are befogged by doubt as to whether or not they have ever had medical or surgical training sufficient to qualify them for undertaking the most simple of operations. Indeed, it is not clear in some cases that they have even graduated from reputable medical schools or obtained their licensure by proper examination. The aspirant for facial reconstruction would do well to inquire carefully into these matters before submitting himself to the scalpel."

In the 1920's and 30's, these physicians referred to themselves not as plastic or cosmetic surgeons but as "featural surgeons," and their letterhead promoted facial rejuvenation, featural contouring and decorative surgery. Today, we see similar use of misleading titles and terminology, often for the purpose of masking a lack of legitimate credentials.

In 1937, the American Board of Plastic Surgery was established and set specific guidelines for the plastic surgery specialty. These standards of training and surgical performance served us well for many years -- until the last decade when a flurry of unrecognized specialty boards and subspecialty designations were created by self-serving physicians whose primary motives in this endeavor appear to be deception and greed.

Since 1978, physician advertising has mushroomed, and plastic surgery has been harder hit than any other medical specialty. Ads for so-called plastic surgeons have ranged from ridiculous and sensational to clearly fraudulent. Not only the training of these doctors has been misrepresented but also the surgical facilities in which operations are performed.

ADVERTISING: A DOUBLE-EDGED SWORD

Although, in principle, advertising is supposed to decrease the cost of medical care to consumers by increasing competition, the result is not so simple. For example, an individual who spends $100,000 on advertising a cosmetic surgery facility, which also has an overhead cost of $100,000, needs to generate at least $200,000 in net income just to break even. Therefore, it becomes imperative for such an individual to develop a high volume practice. We have seen such cases where the cost of excessive advertising campaigns has necessitated increased patient turnover, internal cost-cutting affecting the quality of facilities and services, and use of inappropriate staff. When the triangle of morality, ethics and professionalism, which represents the guiding principles of responsible medical care, is overturned by base greed, the patient is always the one who suffers.

Office surgery, despite the expense of its maintenance and promotion, has the potential to create significant income for the physician who operates in his own facility. This is part of the attraction for untrained doctors motivated solely by self-interest. Additionally, and probably most important, the office surgical facility provides an opportunity for unqualified doctors to perform surgeries for which they cannot receive privileges in the hospital setting. The lack of peer review and standardization of facility requirements allows these doctors to operate in a substandard environment, using inappropriate staff and subjecting patients to significant risks which are entirely unnecessary and unjustifiable.

CONTROLS ON OFFICE SURGERY

It is evident that office surgery is an area in which guidelines and controls must be instituted. This is absolutely essential so that unqualified physicians who are hiding their lack of training from patients and avoiding the scrutiny of hospital peer review can be systematically weeded out. It is ludicrous to think that tatoo artists, hairdressers and manicurists need licensing and/or health board examination to practice their specific art, while a physician can perform any kind of specialized surgery in his office with only a general medical license.

In contrast to this lack of responsible restriction on the performance of office surgery are the policies established by The American Association for Accreditation of Ambulatory Plastic Surgical Facilities, Inc. (AAAAPSF). Prior to accreditation by AAAAPSF, a physician must be board-certified in plastic surgery (certification by the American Board of Plastic Surgery) and have privileges in his hospital for any procedures which he proposes to perform in his office facility. Obviously, the physicians who have been described earlier in this presentation would not be eligible for accreditation by AAAAPSF because they do not meet our standards for training nor is it likely that their facilities would qualify under our stringent guidelines for quality ambulatory surgical care.

It is a fact of life that no surgery is risk-free, and problems can arise even when the surgeon is highly qualified and the facility meets all reasonable standards. Obviously, the incidence of serious complications will be much less when the surgeon is properly trained in patient selection and in the correct methods of medical and surgical treatment. The surgeon who is board-certified in plastic surgery is well prepared to handle complications when they unavoidably occur. The training of the board-certified plastic surgeon, operating in a fully accredited facility, is the best available assurance of quality care for the patient.

SUMMARY

We believe strongly that steps must be taken to establish and maintain national standards for accreditation of office surgery facilities, and that accrediting organizations such as JCAHO, AAAHC and AAAAPSF must be recognized to assist in this effort. Furthermore, the public must be better educated about the risks of surgery, the meaningful qualifications of surgeons, and the importance of facility accreditation. The Federal Trade Commission must also do its part to protect the medical consumer. It must stringently enforce regulations governing truth in advertising and must give special attention to eliminating false and misleading advertising in the plastic surgery specialty. Without swift and thorough action on the part of appropriate agencies, many more innocent people will be victimized by greedy and unscrupulous doctors falsely bearing the title "plastic surgeon" and taking refuge in unaccredited and substandard office surgical facilities.

ATTACHMENTS FOR DR. GUSTAVO A. COLON's TESTIMONY

ATTACHMENT I: ARTICLE FROM DR. COLON
    CURRENT THERAPY IN PLASTIC & RECONSTRUCTIVE SURGERY

ATTACHMENT II: PLASTIC SURGERY BY OTHER THAN AMA APPROVED, CERTIFIED PLASTIC SURGEONS
    A: TEXAS PHYSICIAN - LIPOSUCTION
    B: NEW YORK PHYSICIAN
        1) DECEPTIVE ADVERTISEMENT
        2) RESULTS OF DECEPTIVE ADVERTISEMENTS

ATTACHMENT III: HISTORICAL PERSPECTIVE
    A: TWENTIETH CENTURY CHARLATANS
    B: THE NEW MEDICAL FOLLIES
        BY MORRIS FISHBEIN, M.D.

ATTACHMENT IV: ADVERTISING
    A: ADVERTISING AND THE FEDERAL TRADE COMMISSION(FTC)
    B: ASPRS POSITION ON ADVERTISING

ATTACHMENT V: AMERICAN MEDICAL ASSOCIATION
    RESOLUTION NUMBER 102

OFFICE SURGERY

GUSTAVO A. COLON, M.D., F.A.C.S.

Ambulatory surgery in the past 10 years has risen rapidly because of consumers' needs for less expensive health care of excellent quality and convenience. The major stimulus for its conception and maturation has been a savings in health care cost, which is passed on to the patient. Three ambulatory surgical concepts have developed. The first one is a hospital outpatient facility, attached to the hospital's operating rooms, which may have separate beds or recovery units for ambulatory or outpatient surgery. The second is a freestanding surgical facility, not associated or attached to any hospital, which treats ambulatory surgery patients but has no facilities for overnight or long-term recovery. The third concept is the office surgical facility, which is usually a specialty facility attached to a physician's office.

Obviously, the reason for ambulatory surgical facilities is to decrease the cost to patients. There is no question that outpatient surgery decreases the ultimate cost to both the patient and third party payers. Patients, in particular, like the global, or total, charges because they know exactly what the surgical procedure, anesthesia, and recovery room costs will be. These costs are less because office and ambulatory surgical facilities require fewer staff than hospitals.

GENERAL PATIENT SELECTION AND CRITERIA

Elective procedures for cosmetic surgery lead themselves extremely well to outpatient office surgery. The only limiting factors are medical contraindications that may require hospitalization. However, all office facilities must be equipped to handle any necessary medical or surgical emergency. Age should only be a consideration if the patient's general health warrants careful postoperative monitoring in a hospital setting. Otherwise, if the patient's general health is good, I do not hesitate to treat patients in ambulatory surgical settings, unless they need to have other procedures performed, either at the time of the initial operation or secondarily, that would require hospitalization.

It is imperative that all outpatients have someone drive them home. Also, the patient should arrange to have someone spend the day and evening of surgery with them, as well as the following day. All patients are called by the office staff during the evening after surgery and the following day to check on their condition. Specific postoperative orders are given to the patient. These orders are given, both written and verbally, to the individual who will take care of the patient when he or she is discharged from the surgical ambulatory facility. Patients who come from out of town are sent either to convalescent care centers or to their hotel. Occasionally, a patient will request transfer to a hospital after the ambulatory surgery. This is arranged with the hospital, so that the patient can be admitted for a one or two-day hospitalization after the surgery.

Coexisting medical problems must be evaluated preoperatively. While they may not contraindicate outpatient surgery, each case has to be evaluated individually. Heart disease, pulmonary disease, diabetes, or any chronic illness that may require hospitalization or intensive postoperative care, certainly negate ambulatory surgery. Also, patients who seem to be high anesthetic risks should not be treated in an ambulatory surgical facility. Office surgical suites should be a safe surgical environment where elective surgery assures predictable results.

SURGICAL PROCEDURES

Category of Operations

1. Many reconstructive plastic surgical procedures that do not invade body cavities and do not require long-term care or multiple procedures can be done on an outpatient basis.
2. Most esthetic surgery can be done safely and economically for the patient in an office surgical suite.

3. Hand surgery is very amenable to outpatient surgery since many procedures can be done under local or regional block anesthesia. Most elective hand surgery today is done on an outpatient basis in either a hospital ambulatory surgical setting or a freestanding surgical facility.
4. Pediatric plastic surgery can be done on an outpatient basis. Pediatric operations are one of the most common types of outpatient surgery e.g., tonsillectomy, herniorrhaphy. These procedures generally are done in a freestanding surgical facility or the hospital outpatient facility. I have found that in an office surgery facility the recovery facilities for children are not as adequate as in the hospital. Office facilities have physical restraints in equipment size, i.e., they are designed for adults. Therefore surgeons with office operating facilities generally do not do a great volume of pediatric surgery.

SUPPORTING FACILITIES

Radiologic diagnostic facilities and pathology (either frozen of permanent sections) are contracted to outside consultants. These consultants service, supply, and support these outpatient facilities. Blood and blood substitutes are included.

INSPECTION AND ACCREDITATION

Inspection and accreditation of hospital facilities has been primarily done by the Joint Commission for Accreditation of Hospitals (JCAH). Freestanding ambulatory surgical facilities also are inspected by the JCAH as well as by the Accreditation Association for Ambulatory Health Care Facilities (AAAHC). This is an association that can accredit both freestanding surgical facilities and office facilities. Specialty facilities such as plastic surgery are now being accredited by the American Association for Ambulatory Plastic Surgical Facilities (AAAPSF). This association classifies office facilities into:

Class A	A facility in which minor plastic surgical procedures are performed under local, regional, or topical anesthesia.
Class B	A facility in which both minor and major plastic surgery procedures are performed under intravenous or parenteral sedation: analgesia or disassociative drugs.
Class C	A facility in which major plastic surgical procedures are performed under general anesthesia that requires external support of vital body functions.

No facilities are accredited for elective surgery of major body cavities. Certain states, such as the state of Louisiana, have specific accreditation criteria and licensing for ambulatory surgical facilities. Accreditation of freestanding surgical facilities and hospital facilities generally requires acquisition of a certificate of need from a state licensing board. However, at the present time, office facilities do not require this type of certification, nor do they require state licensing.

Applicable State and City Laws Regarding Such Facilities

At present, there are no federal guidelines for ambulatory surgical facilities. In 1983, the Federal Government outlined guidelines for reimbursement from Medicare to ambulatory surgical facilities. Individual states have rules and regulations for Medicaid reimbursements to ambulatory surgical facilities. These may vary from state to state. It is imperative, at the present time, that all physicians who do outpatient surgery make both State and Federal Governments aware of the cost savings that can be incurred through encouragement and promotion of outpatient surgery.

REIMBURSEMENT

At the present time, all ambulatory surgical facilities are well regarded by the insurance companies, which feel that ambulatory surgery is cost-saving for the third-party payers. It minimizes hospitalization and, obviously, the cost to the patient and the insurance company. One of the factors that has made reimbursement to free ambulatory surgical facilities and office surgical facilities very desirable to insurance companies is that these facilities can offer global, or total, procedure charges, i.e., charges per operative procedure rather than charges per time, unit or operation, or per item used in the outpatient facility. Reimbursement for outpatient surgery in hospital facilities and freestanding facilities is now routinely done by third-party payers. Office surgical facilities, as they become more numerous and accredited, are being treated by insurance companies in the same fashion as freestanding and hospital facilities.

ADVANTAGES AND DISADVANTAGES

Hospital outpatient surgical facilities are patient effective in that they increase the volume of patients processed through the hospital operating room, but they are not really cost effective. Because hospital outpatient facilities are usually very successful, they begin to help carry the financial losses in other parts of the hospital. This causes the charges for ambulatory surgery to rise. Ultimately, the cost of outpatient surgery equals the cost of inpatient surgery, without the costs of hospital room.

Freestanding surgical facilities have paved the way for ambulatory surgery and they have succeeded because:

1. They reduce health care cost.
2. More than 40 percent of all elective surgical procedures, can be performed on an outpatient basis.
3. The charges of freestanding surgical facilities can be at least half the comparable hospital outpatient costs.
4. They are financially viable. Ambulatory surgical facilities can lower community costs because: (a) they eliminate overnight hospital stay, thereby decreasing personnel cost; (b) some unnecessary diagnostic tests and non essential drugs can be eliminated; (c) they uti-

lize their facilities and staff much more efficiently; and (d) there is an easier recovery period at home for the patients.

Office and specialty facilities have other specific advantages in that they not only reduce the cost of surgical care but they also make more effective use of physician's time because:

1. Time consuming hospital formalities are reduced.
2. There is more efficient time use because the physician is in his office; between operations he can do some office work and even see other patients.
3. Freestanding ambulatory surgical and office facilities provide a comfortable setting for patient and family.
4. These facilities streamline the delivery of surgical services because the operations can be patient specific and procedure specific, with less waste and more privacy. This has a great patient appeal, as well as convenience for both the patient and surgeon.
5. There are economic advantages to the patient because secondary procedures can be done in an office facility at, perhaps, no charge to the patient.

Ambulatory surgical facilities stress that they have a lower infection rate than hospitals because they are dealing with a more healthy patient population.

Office surgical facilities have the same experience. Not only do they have a healthier population, but, since fewer doctors use the facilities and the procedures are usually unispecialty, the infection rate is even lower. In our surgical facility, surgi-unit, in over 2,000 procedures done over 9 years we have had no infections.

The disadvantages of outpatient office surgery are:

1. Patients' resistance because they are used to going to the hospital.
2. Physicians' resistance because they are used to operating in more familiar surroundings, and are creatures of habit.
3. Reduced hospital income.
4. Loss of contact with colleagues in the hospital.

ESTHETIC PROCEDURES THAT CAN BE DONE IN OFFICE SURGICAL SUITES

While many minor surgical procedures can be done on an outpatient basis, experience shows that many more procedures of esthetic surgery can be done in our office surgical facility. The program that we have in our surgi-unit involves informing the patient completely about preoperative arrangments. The patient is seen in the first office visit by our patient coordinator, who instructs and advises him or her about the operative procedures and shows them videotapes—not only of the facility, but also of the procedure that is to be performed. The patient is then scheduled for surgery and, during a preoperative visit, he or she is given the *postoperative* medication. There is no *preoperative* medication given except at the time of initial evaluation on the morning of surgery. The patient has the following laboratory work done: urinalysis, complete blood count, partial thromboplastin time test, electrolytes, electrocardiogram, and chest x-ray study, as necessary and required by the physician. Preoperative instructions are given at that time. On the morning of surgery, the patient comes in and has taken no medication. He or she is given Ativan, per body weight, intravenously 20 minutes before surgery; then, if local standby anesthesia is to be used, he or she is given a combination of Ativan and Sublimaze (Tables I and II). The patient then undergoes the surgical procedure. Since our surgi-unit is a class C facility, procedures can be done either with local standby anesthesia, or general anesthesia, with or without intubation.

Facial esthetic procedures that can be done in the office facility are facelifts with coronal lifts, blepharoplasties, rhinoplasties, otoplasties, liposuction of the head and neck, mentoplasties or chin implants, scar revisions, dermabrasions, excision of multiple facial lesions, and reconstruction. Body contouring procedures can also be done—usually under general anesthesia. These procedures are liposuction of the trunk, abdomen, and extremities. Even a small, lower abdominoplasty can be done. As regards breast surgery, breast augmentation is certainly done on an outpatient basis in our facility, as well as mastopexies, small reduction mammoplasties, breast reconstructions with expanders or with implants, and removal of gynecomastia.

We find that many more operative procedures that fall within the armamentarium of the plastic surgeon can now be done within an office surgical facility because of the increase in third party payers who require outpatient surgery for cost containment.

The office surgical facility receives the third party reimbursement.

The future of office surgery is limitless. We, as the leaders in office surgery, must inspect, accredit, and strive for excellence, safety, and security for our patients in all

TABLE 1 Sedation Dosages

Ativan (Lorazepam) 0.04 mg/kg	Intravenously push slowly 20 min preoperatively
Sublimaze (Fentanyl) 0.05 mg/cc	½ cc intravenously push initially before surgery and ½ cc every half hr as needed Total Range: 2–6 cc

TABLE 2 Procedures Done in Surgi-Unit Using Ativan-Sublimaze

1981–1983 (36 Months)

Augmentation mammoplasty	207	Mentoplasty	14
Mastopexy	27	Coronal lift	15
Breast reconstruction	10	Otoplasty	5
Rhytidectomy	62	Gynecomastia	7
Blepharoplasty	71	Suction lipectomy	28
Rhinoplasty	135	Other local/standby surgical procedures	286

Total Procedures 867

office surgical facilities, and zealously guard against the lure of entrepreneurism and unqualified office surgical facilities.

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Office surgery: an old concept modernized

Ambulatory surgery has arisen from a rapidly growing consumer need
for less expensive health care of excellent quality and convenience.

GUSTAVO A. COLON, MD, FACS
JOHN M. CHURCH, JR., MD, FACS
Metairie

Historically, medicine and surgery began as outpatient care. India, Egypt and Greece had houses and even temples that were transient refuges for the sick.

The modern outpatient clinic idea really originated with Galen, in the first century A.D. as "Tabernae Medicae" for the care of the ambulant sick. However, for the next 15 centuries, medicine sank into the deep abyss of the Dark Ages.

In the Middle Ages patient care developed in a hospital setting from the influence of the Eastern Roman Empire on the European Crusades and flourished in Medieval Monastic and Ecclesiastic orders such as, the Knights of St. John (or hospitalers). Over the next few centuries, medicine evolved from superstitious beliefs into scientific endeavor and by the early 19th-century outpatient medicine had developed, but this was nothing more than dispensaries and prescription mills.

The discovery of anesthesia ushered in the era of outpatient surgery in the glow of promises of painless surgery. Unfortunately, it dimmed and nearly died in the false hopes of quackery, gimmickry and illicit surgery. The rise of hospital accreditation, specialty boards and influenced by third-party payers and government regulations kept until recently most surgeries within the hospital confines.

However, in the late 1960's

1. New anesthetic techniques,
2. Increasing early postoperative ambulation,
3. High demand for patients' beds,
4. Potential cost savings, and
5. Convenience to patient and physician finally, pushed ambulatory surgery into the forefront of medicine.

The advantages of ambulatory surgical facilities are self-evident:

Presented to the New Orleans Chapter of the American College of Surgeons, November, 1980.

Dr. Colon's address is 4204 Teuton Street, Metairie, LA 70002.

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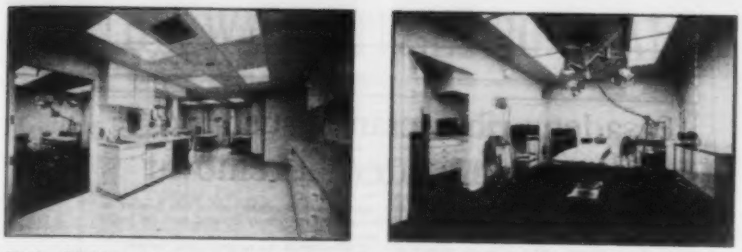

Figs 1 and 2. SURGI-UNIT — example of the growing concept of surgical facilities in an office setting.

1. They reduce cost of surgical care.
2. They make more effective use of the physician's time because of less time-consuming hospital formalities.
3. They have a pleasant setting for patient and family.
4. They streamline delivery of surgical services because the operations can be patient specific and procedure specific with less waste.
5. There is an easier recovery period at home.

The disadvantages to outpatient ambulatory surgery are:

1. Patients' resistance because they are used to going to the hospital.
2. Physicians' resistance because they are used to operating in more familiar surroundings and are creatures of habit.
3. Reduced hospital income.
4. Loss of contact with colleagues in the hospital.

However, in spite of these disadvantages ambulatory surgical facilities have been favorably viewed by state and federal health agencies because:

1. They reduce health care cost.
2. Of all elective surgical procedures 20 to 40% can be performed on outpatients.
3. The charges of free-standing surgical facilities can be 50 to 60% less than comparable hospital outpatient costs.
4. Financially viable ambulatory surgical facilities can lower community costs because:
    a. they eliminate overnight hospital stays, therefore, less personnel cost.
    b. purely nondiagnostic tests and nonessential drugs can be eliminated.
    c. utilize their facilities and staff more efficiently.

There are three basic types of outpatient surgical facilities:

1. The hospital controlled facility which is patient efficient but rather costly.
2. Free-standing ambulatory surgical facility.
3. Surgical suite in the physician's office.

SURGI-UNIT is only one example of the growing concept of ambulatory surgical facilities in an office setting (Fig 1-2), primarily for plastic and reconstructive surgery, but with the capabilities of use by other surgeons. These units are designed to protect patients and insure quality surgery with equipment comparable to hospital operating-rooms.

The patients are, usually, more satisfied and have greater privacy than patients who have had hospital day surgery.

Summary

Ambulatory surgery has arisen from a rapidly growing consumer need for less expensive health care of excellent quality and convenience. The major stimulus for its conception and maturation has been a savings in health care costs which is passed on to the patient. However, this trust must be zealously guarded to protect against the lure of entrepreneurism.

The JCAH, American Association for Accreditation of Ambulatory Plastic Surgical Facilities and the Accreditation Association for Ambulatory Health Care, have programs to provide accreditation and inspection of these surgical facilities. Because of the rapidly changing medical milieu the future for ambulatory surgical care is bright and secure in providing and continuously striving for excellence, safety and security to patients' needs.

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Pasadena physician is suspended when two die after fat removal

The Associated Press

AUSTIN – The Texas Board of Medical Examiners' executive committee Friday temporarily suspended a doctor's license in an investigation of the deaths of two women who had fat removal surgery at his Pasadena clinic.

Texas

A full hearing before the entire board on the allegations against Dr. Hugo A. Ramirez will be held at a later date, officials said.

Allegations considered by board examiners in a five-hour emergency meeting centered around three women who went to Ramirez for the liposuction procedure, in which fatty tissue is removed from under the skin.

Two died later in Houston hospitals from infections and another is in critical condition, officials said.

Dr. Simon Fredricks, chief of plastic surgery at three Houston hospitals, testified that Ramirez' records show he "grossly deviated from the proper standards of care."

"I do not think this surgery is safe," he said.

Dr. G. V. Brindley Jr., executive director of the medical examiners' board in Austin, said earlier that Ramirez has been under investigation by state officials since March 5 when a complaint was filed against him.

Ramirez did not testify at the hearing because, his attorney Marion Rosen said, the atmosphere was not right to present the doctor's case.

Members of the three-member executive committee stressed repeatedly their only duty was to determine if Ramirez was an imminent peril to the public and should have his license suspended immediately.

The committee refused an offer from Ramirez' attorney to delay the hearing.

Fat-removal doctor is under investigation

The Associated Press

HOUSTON – A doctor who performed fat-removal surgery on a woman who died and another who was in critical condition Thursday is under investigation by county and state health officials.

Patsy Howell, 39, died Monday at St. Luke's Episcopal Hospital four days after undergoing a suction-assisted lipectomy at Hugo Ramirez's clinic.

Ramirez has been under investigation since March 5 when a complaint was filed against him, said Dr. G. Valter Brindley Jr., executive director of the Texas State Board of Medical Examiners.

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Getting Remodeled

Fat-Cutting Surgery Gains Wide Popularity But Can Be Dangerous

Patients Express Satisfaction; M.D.'s License Challenged After Texas Woman Dies

Smoothing Out the Contours

By Carrie Dolan
Staff Reporter of The Wall Street Journal

SAN FRANCISCO — The doctor carefully studies the woman's legs. "I'm going to take out this fat pad," he says, to create "a far more idealized, beautiful view." He slides a slender tube into her thigh and vigorously pulls it back and forth. Moments later he asks the anesthesiologist, "Ho[illegible] contour look?" The other man sizes up the downsized thigh. "That will look nice in a bikini," he says.

Cosmetic surgery used to mean a nose job or a face lift. Now you can practically trade yourself in for a new model. "There is less and less we can't do," says Carson Lewis, a plastic surgeon in La Jolla, Calif. "We can literally be like a sculptor of the human body. It boggles the mind."

The main weapon in this revolution is liposuction — spot surgery to suck off unwanted fat through a hollow tube. Introduced into the U.S. five years ago, it has become one of the most popular, and controversial, forms of cosmetic surgery. About 100,000 Americans went through it last year.

No Cure for Obesity

Liposuction — called lipoplasty by plastic surgeons — doesn't cure obesity. In fact, many people who get their fat sucked aren't fat. Patients are usually people who are unhappy with their looks or their contours.

"I couldn't even use eye shadow or wear Guess jeans" before two liposuctions, says Linda Martonik, 46, of Vista, Calif. The 5-foot-5, 126-pound woman spent $10,000 to have her eyes, stomach, hips, thighs and knees sucked. She is extremely happy with the results. "I don't think there's any mor[illegible] can do," she says.

[illegible] Grimes, 41, of Escondido, Calif., has had fat sucked out of her upper eyelids, upper hips, outer thighs, stomach, inner thighs and knees over the past three years. "Remember the TV show about the guy they rebuilt, called the 'Six Million Dollar Man'?" she asks. "My husband calls me the $6,000 woman."

Some find the practice disturbing. Lonnie Barbach, a social psychologist and author of books on female sexuality, says, "It's a very sad commentary on our culture that people are so controlled by a media-generated image of beauty that they're willing to undergo radical changes, and undergo pain, at great expense." Cosmetic surgery, she says, "seems to be one of the areas where technology gets ahead of us to an absurdity."

'A Kind of Pop-Darwinism'

Body jobs are just one of several medical advances that could make the future a bit eerie. A recent prize-winning science-fiction novel, "Neuromancer," envisions a world obsessed with black-market hormones, body implants and cosmetic surgery. In an interview its author, William Gibson, neither praised nor condemned liposuction, but he speculated that if cosmetic surgery becomes more widespread, "we'll see a strange kind of pop-Darwinism take hold; we'll start seeing the same faces over and over, [conforming to] fashion, a kind of Barbie doll effect."

Increasingly, the middle class can afford even extensive body jobs, because costs are falling as doctors compete for the fat profits up for grabs. But some doctors and others warn that the rush to capitalize on this lucrative procedure may pose hazards more ominous than saddlebag thighs. Liposuction can be dangerous.

Patsy Howell, 38, a florist from Baytown, Texas, wanted to look better in her swimsuit, so the 115-pound mother of two had liposuction done in March. Three days later, she died of infection. Patricia Rogers, 31, of Pasadena, Texas, had a liposuction the same day from the same doctor. She, too, suffered a severe infection, and remains hospitalized. All the skin from below her breast to the top of her thigh had to be removed, and skin grafts are required.

License Challenged

The Texas Board of Medical Examiners has temporarily suspended — and will consider revoking — the license of Hugo Ramirez, the gynecologist who performed the operations. (However, a federal judge has allowed Dr. Ramirez to continue practicing medicine, but not surgery, until the board makes its decision.)

These aren't isolated cases, says Robert Ersek, an Austin plastic surgeon who testified before the Texas board. There have been at least six other deaths related to liposuction, he says. He charges that misleading ads and doctors ill-trained in liposuction are rampant. "There are bands of mavericks profiteering on the fringe of medicine," Dr. Ersek says. "The training is so shallow . . . it's immoral."

Lannis Temple, attorney for Mrs. Howell's husband, alleges that "doctors are rushing in for the money, and some aren't qualified." He adds, "Under existing rules, anybody can sign up for a hotel seminar and start doing it." Mr. Temple, who last year had fat around his own waist removed, stresses that the procedure is safe when done by a well-trained doctor.

For operations performed in a hospital, the hospital's board must grant approval, and approvals aren't knowingly granted to the unqualified. Most cosmetic surgery,

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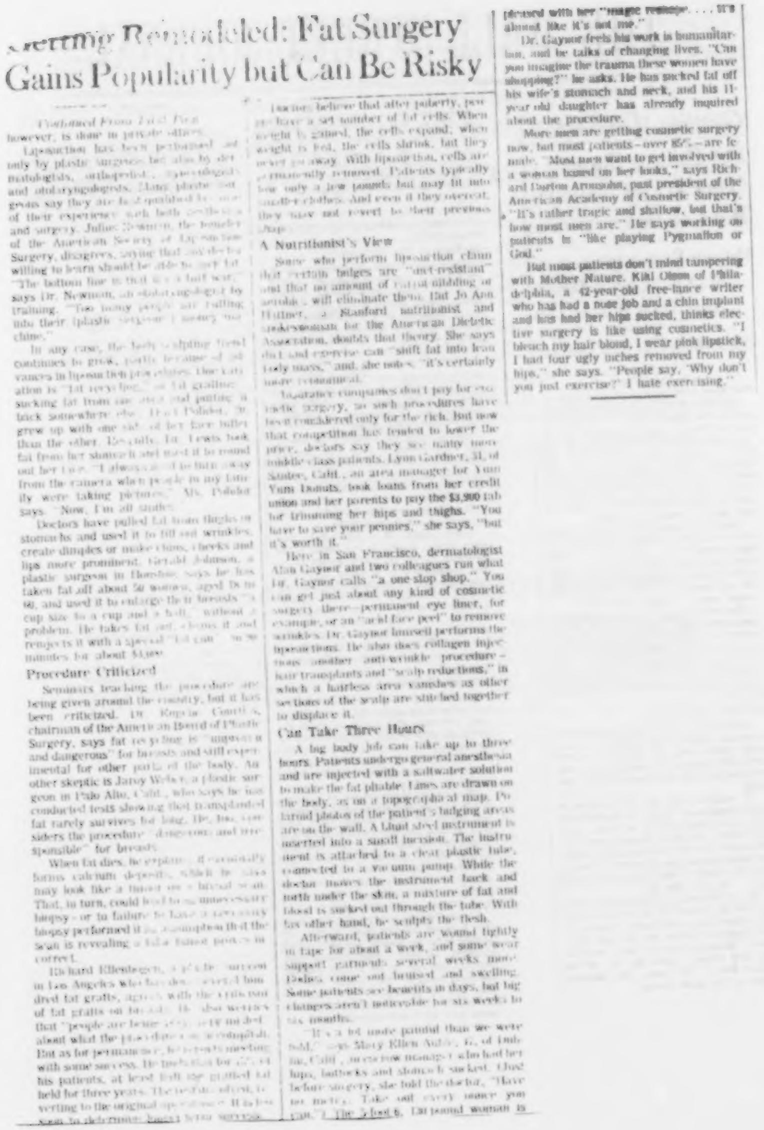

Getting Remodeled: Fat Surgery Gains Popularity but Can Be Risky

Continued From First Page

however, is done in private offices.

Liposuction has been performed not only by plastic surgeons but also by dermatologists, orthopedists, gynecologists and otolaryngologists. Many plastic surgeons say they are best qualified because of their experience with both aesthetics and surgery. Julius Newman, the founder of the American Society of Liposuction Surgery, disagrees, saying that any doctor willing to learn should be able to suck fat. "The bottom line is that it's a turf war," says Dr. Newman, an otolaryngologist by training. "Too many people are cutting into their (plastic surgeons') money machine."

In any case, the body-sculpting trend continues to grow, partly because of advances in liposuction procedures. One variation is "fat recycling," or fat grafting: sucking fat from one area and putting it back somewhere else. Traci Polisher, 20, grew up with one side of her face fuller than the other. Recently, Dr. Lewis took fat from her stomach and used it to round out her face. "I always used to turn away from the camera when people in my family were taking pictures," Ms. Polisher says. "Now, I'm all smiles."

Doctors have pulled fat from thighs or stomachs and used it to fill out wrinkles, create dimples or make chins, cheeks and lips more prominent. Gerald Johnson, a plastic surgeon in [illegible], says he has taken fat off about 50 women, aged 18 to 60, and used it to enlarge their breasts "a cup size to a cup and a half," without a problem. He takes fat out, cleans it and reinjects it with a special "fat gun" in 90 minutes for about $3,000.

Procedure Criticized

Seminars teaching the procedure are being given around the country, but it has been criticized. Dr. [illegible] Courtiss, chairman of the American Board of Plastic Surgery, says fat recycling is "unproven and dangerous" for breasts and still experimental for other parts of the body. Another skeptic is [illegible], a plastic surgeon in Palo Alto, Calif., who says he has conducted tests showing that transplanted fat rarely survives for long. He, too, considers the procedure "dangerous and irresponsible" for breasts.

When fat dies, he explains, it eventually forms calcium deposits, which he says may look like a tumor on a breast scan. That, in turn, could lead to an unnecessary biopsy—or to failure to have a necessary biopsy performed if the assumption that the scan is revealing a false tumor proves incorrect.

Richard Ellenbogen, a plastic surgeon in Los Angeles who has done several hundred fat grafts, agrees with the criticism of fat grafts on breasts. He also worries that "people are being very misled about what the procedure can accomplish." But as for permanence, he reports meeting with some success. He [illegible] for [illegible] of his patients, at least half the grafted fat held for three years. The rest dissolved, reverting to the original appearance. It is too soon to determine longer-term success.

Doctors believe that after puberty, people have a set number of fat cells. When weight is gained, the cells expand; when weight is lost, the cells shrink, but they never go away. With liposuction, cells are permanently removed. Patients typically lose only a few pounds but may fit into smaller clothes. And even if they overeat, they may not revert to their previous shape.

A Nutritionist's View

Some who perform liposuction claim that certain bulges are "diet-resistant" and that no amount of carrot-nibbling or aerobics will eliminate them. But Jo Ann Hattner, a Stanford nutritionist and spokeswoman for the American Dietetic Association, doubts that theory. She says diet and exercise can "shift fat into lean body mass," and, she notes, "it's certainly more economical."

Insurance companies don't pay for cosmetic surgery, so such procedures have been considered only for the rich. But now that competition has tended to lower the price, doctors say they see many more middle-class patients. Lynn Gardner, 31, of Santee, Calif., an area manager for Yum Yum Donuts, took loans from her credit union and her parents to pay the $3,900 tab for trimming her hips and thighs. "You have to save your pennies," she says, "but it's worth it."

Here in San Francisco, dermatologist Alan Gaynor and two colleagues run what Dr. Gaynor calls "a one-stop shop." You can get just about any kind of cosmetic surgery there—permanent eye liner, for example, or an "acid face peel" to remove wrinkles. Dr. Gaynor himself performs the liposuctions. He also does collagen injections, another anti-wrinkle procedure—hair transplants and "scalp reductions," in which a hairless area vanishes as other sections of the scalp are stitched together to displace it.

Can Take Three Hours

A big body job can take up to three hours. Patients undergo general anesthesia and are injected with a saltwater solution to make the fat pliable. Lines are drawn on the body, as on a topographical map. Polaroid photos of the patient's bulging areas are on the wall. A blunt steel instrument is inserted into a small incision. The instrument is attached to a clear plastic tube, connected to a vacuum pump. While the doctor moves the instrument back and forth under the skin, a mixture of fat and blood is sucked out through the tube. With his other hand, he sculpts the flesh.

Afterward, patients are wound tightly in tape for about a week, and some wear support garments several weeks more. Bodies come out bruised and swelling. Some patients see benefits in days, but big changes aren't noticeable for six weeks to six months.

"It's a lot more painful than we were told," says Mary Ellen [illegible], [illegible], of [illegible], Calif., an escrow manager who had her hips, buttocks and stomach sucked. Just before surgery, she told the doctor, "Have no mercy. Take out every ounce you can." The 5-foot-6, 130-pound woman is pleased with her "magic [illegible]. . . . It's almost like it's not me."

Dr. Gaynor feels his work is humanitarian, and he talks of changing lives. "Can you imagine the trauma these women have shopping?" he asks. He has sucked fat off his wife's stomach and neck, and his 11-year-old daughter has already inquired about the procedure.

More men are getting cosmetic surgery now, but most patients—over 85%—are female. "Most men want to get involved with a woman based on her looks," says Richard Barton Aronsohn, past president of the American Academy of Cosmetic Surgery. "It's rather tragic and shallow, but that's how most men are." He says working on patients is "like playing Pygmalion or God."

But most patients don't mind tampering with Mother Nature. Kiki Olson of Philadelphia, a 42-year-old free-lance writer who has had a nose job and a chin implant and has had her hips sucked, thinks elective surgery is like using cosmetics. "I bleach my hair blond, I wear pink lipstick, I had four ugly inches removed from my hips," she says. "People say, 'Why don't you just exercise?' I hate exercising."

'Women feel they have to be superthin'

'Simple' solution, deadly result

By D.J. WILSON
and LOU JAKOVAC
Post Reporters

Five days before her death, Patsy Howell told a friend she had found an easy solution for the slight paunch to her 5-foot-1-inch, 120-pound frame.

"She realized she didn't have a weight problem," Howell's close friend, Rheba Downey, recalled Wednesday. "But this literature she got at a shopping mall said the procedure was so simple. She said, 'Why not?' "

Downey said Howell had wanted to look fit in her bathing suit for the family's upcoming summer vacation.

"There was to be nothing to it. She left work Thursday and planned to be back Monday," she said.

Instead, Howell died in a hospital bed Monday, four days after undergoing suction-assisted lipectomy, a surgical procedure designed to remove fat deposits by suction.

Howell's husband, Mark, said he did not see the need for the surgery.

"It's in our society today that women feel they have to be superthin and look like a model," he said from his mother's Baytown home.

"My wife was 39 and had two kids. I told her there was no way her body could go back to how she was when she was 18. And I liked her the way she was," he said.

But, Patsy Howell underwent the surgery anyway. She developed a 102-degree fever afterward. On Sunday, she went to Humana Hospital in Pasadena but was transferred Monday to St. Luke's Episcopal Hospital.

The Howells had been married slightly more than a year. She had two sons, ages 11 and 17, from a previous marriage. She was a manager for two flower and gift shops in Channelview and Highlands.

Downey described Howell as a "happy, vibrant person" and an "easy-going, super boss."

Downey had advised her against the procedure.

"I just told her she didn't need

TGI
WEEKEND E

The Houston Post–Thursday 4/2/37

'Simple' solution, deadly result

'Women feel they have to be superthin'

Continued from page 1A

it. She was a pretty size," she said.

Patricia Rogers, 31, also underwent the procedure Friday and is now in critical condition at St. Luke's.

The physician for both women that day was Dr. Hugo Ramirez, an obstetrician-gynecologist who directs the Pasadena Liposuction Surgical Center. Ramirez is now under investigation by the Harris County Health Department and the state Board of Medical Examiners.

Paul Gavia, director of enforcement for the board, said the state's investigation could be completed within a week. A spokesman for the Harris County medical examiner's office said the autopsy on Patsy Howell had not yet been completed.

Medical records from the two cases have been collected by an investigator from the board. County health department personnel also took specimens from Ramirez's office in a search for bacteria or infectious agents.

Ramirez said Tuesday he had performed more than 200 of the procedures and "never had a problem until now."

Attempts to reach Ramirez Wednesday were unsuccessful.

His lawyer, Marion Rosen, said Ramirez will cooperate with all investigations and is conducting his own internal inquiry. Rosen said he will continue his practice in the interim.

Several local plastic surgeons contended Wednesday Ramirez's advertisements misconstrued the correct purpose of the surgery.

Ramirez advertised the surgery, usually called liposuction, in newspapers and brochures and on billboards. One of his newspaper ads called the procedure "the revolutionary technique for reduction of fat without dieting."

MARK HOWELL
Saw no need for surgery

Critics of Ramirez's practice, however, said liposuction was never meant solely for weight reduction, but more to remove fat from "genetically pre-determined storage areas."

Dr. Joseph Agris, a Houston plastic surgeon who has written a textbook on the technique, said it was designed to affect body contour and not primarily for weight reduction. If a person had fat deposits in one area of his or her body that could not be removed by diet or exercise, then he might be a candidate for the surgery.

Dr. Simon Fredricks said he knew of other of Ramirez's patients who he said had complications after the procedure. He also said he knew "of no other doctor in the country who had the number of complications" that Ramirez has had with patients.

Fredricks said he was the first surgeon in the area to perform suction-assisted lipectomy, doing the procedure in February 1982 with the assistance of Dr. Gerard Illouz, the technique's originator.

Fredricks also stressed the importance of liposuction's being performed by a surgeon experienced in the technique.

"It's time for the state board to address the problem of practitioners doing the procedure when they are ill-equipped and not qualified," said Fredricks, who is chief of plastic surgery at St. Luke's.

"By doing these in a frivolous and cavalier manner, they are doing harm to an unsuspecting public," he said.

Dr. Franklin Rose, who said he has performed the procedure hundreds of times, also questioned the value of advertising. "The best referral source is word of mouth," he said.

Rose and other plastic surgeons said they received numerous phone calls from patients who were contemplating the surgery but are now in a "panic." He added that the procedure is one of the most common and safest procedures performed by plastic surgeons.

Fredricks estimated more than 100,000 of the surgeries have been completed nationwide.

Though the ultimate cause of Howell's death and Roger's hospitalization was uncertain, several physicians argued it could be connected to some type of infection. Complications could have also been caused, they said, by either too much fat tissue being removed at one time or by insufficient blood transfusions being administered.

Plastic surgeons also reiterated a belief that liposuction should be performed by a board-certified plastic surgeon. Current law now permits any physician licensed to practice medicine to perform the surgery.

Mark Howell, meanwhile, said he has talked to two women who had planned to have the operation.

"We have already stopped two women from having surgery like this, and one of them was going to the same doctor as my wife. That makes us feel real good."

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Newsday Photo / Eugene Richards

Dr. Richard L. Dombroff and his wife, Pamela, with their Rolls Royce in front of their home in Huntington

Cosmetic Surgery for the Masses: An Examination of 'Personal Best'

This story was reported by Newsday staff writer Richard C. Firstman and freelance writer Daniel Kagan. It was written by Firstman.

The first advertisement filled less than two inches of type. It appeared in the New York Post on March 18, 1982, buried under the Medical Services heading of the classified section. "Free consultations," it offered. "Same day surgery." The advertiser was the Personal Best Center. Park Avenue was the address.

Within two years, the Personal Best Center would have an annual advertising budget of more than $1.5 million — most of it for television and radio commercials boasting of cosmetic surgery centers "from New York to Palm Beach to Beverly Hills," but ending with an assurance: "Honestly, only our address is expensive."

The advertising worked: the Personal Best Center would make a millionaire of its founder, chief surgeon and guiding spirit, Richard Laurence Dombroff, a young graduate of the Johns Hopkins University School of Medicine whose Madison Avenue approach to cosmetic surgery would attract thousands of people paying millions of dollars for instant breast enlargements, facelifts, tummy tucks and nose alterations.

His success would generate a national reputation and a cadre of imitators. Four years out of residency, Dombroff would declare in a brochure that he had become "one of the most prominent cosmetic surgeons in the world today."

But the financial success of the 33-year-old Huntington surgeon who sees himself as the "envy of the profession," has been tarnished by a record that would never appear in his *curriculum vitae*. He has amassed what may be the largest number of malpractice claims ever brought against a single doctor in New York State in such a short time. The state Medical Society recommended that his malpractice insurance be canceled and he is under investigation by the state Health Department.

And Dombroff has come under attack by members of his profession — normally a circumspect group reluctant to criticize a colleague in public. Troubled by a high-volume surgical practice that has produced as many as 15 operations a day, some within 30 minutes, they charge that under the Personal Best system, business principles have prevailed over medical standards.

"If this was just a business venture, if he were just selling cars, terrific," said Dr. Alan Gold, president of the New York Regional Society of Plastic and Reconstructive Surgery, who knows Dombroff's work first-hand. "It's extremely clever, well packaged, nicely produced. But what he's doing in medicine, because that happens to be his product, goes beyond monetary loss to significant emotional and physical disfigurement, sometimes which is not reparable."

Dombroff attributes such remarks to competitors jealous of his talent and resentful of his advertising. "They are picking out one scapegoat and that is me," he said. "There is a conspiracy by the New York State and County Medical Societies to drive me out of business because they are fearful of the competition. I am hurting them in the pocketbook."

But court records, private documents obtained by Newsday and interviews with more than 80 of Dombroff's employees, patients, associates and medical peers reveal the following:

- In just four years of practice, Dombroff and Personal Best have been served with at least 28 malpractice lawsuits. Dombroff says this is a small number among the 10,000 patients Personal Best has treated, but malpractice experts said that the number of suits may be unprecedented in such a short time.
- Employees and patients of Personal Best told Newsday that between 1983 and 1985, Dombroff employed three persons who practiced medicine without licenses — an allegation that if proven could cost him his own license and lead to a felony charge carrying penalties of up to four years in prison.
- Office "consultants" with no medical training have been paid commissions for selling surgery at Personal Best. Some patients allege they were misled or given insufficient information prior to surgery and had little or no time with Dombroff.
- Although the firm has advertised centers "from New York to Palm Beach to Beverly Hills" since 1984, the Palm Beach center did not open until this spring and no surgery has ever been performed at the Beverly Hills office.

Dombroff, who talked to Newsday several months ago, has recently refused to discuss specifics without a written guarantee that a verbatim question-and-answer transcript would be published. Newsday informed Dombroff that the newspaper could not promise to publish a complete transcript of an interview but that his views would be reported fairly and fully. He responded in a letter that his demand was "non-negotiable."

* * *

"Over 10,000 happy men and women the world over have found the Personal Best system of same-day cosmetic surgery the only answer to big doctor bills and long hospital stays. So the next time you ask, 'How do I look?' you'll know the answer: Your very best. Your personal best."

—**Pamela Dombroff** in a television commercial.

Richard L. Dombroff grew up in Oceanside, a lawyer's son. He graduated from Johns Hopkins Medical School in 1976. He served an internship at New York Hospital. He was a surgical resident at New York University Medical Center. And he was a chief resident in plastic surgery at New York Hospi-

—Continued on Page 28

An Examination of 'Personal Best'

—Continued from Page 7

tal, where he won a research grant from the American Society of Plastic and Reconstructive Surgeons.

In the summer of 1981, at the age of 29, Dombroff went into private practice. He rented space from another doctor on Park Avenue and worked at a Manhattan plastic surgery clinic that specialized in hair replacement. There he learned something about plastic surgery as a consumer service for the '80s: "There was a demand, an interest that wasn't being exploited," he told an interviewer.

Dombroff and his wife, Pamela, set about to meet that demand. His idea was to sell cosmetic surgery to the masses, to "remove the mystique" from rhinoplasties, abdominoplasties and suction lipectomies — better known as nose jobs, tummy tucks and fat removals. And thanks to a ruling by the Federal Trade Commission in 1978 allowing physicians to advertise, he did not have to wait years and years to build a practice through reputation and referral.

Dombroff did not advertise under his own name. He decided a "concept" would be a better marketing strategy. At first the advertising was modest — small classifieds and commercials on a Spanish-language television station — but Dombroff told an interviewer he discovered a formula: "*For every dollar spent on advertising, three to five come back as revenue.*"

With Pamela Dombroff producing and starring in the television and radio campaign, listeners were offered something new: free consultations and moderate prices. Soon, Dombroff's appointment book began filling up. He hired a staff of assistants and consultants, a limousine driver to ferry the patients and a doorman to greet them. He moved the office from Park Avenue to larger quarters on Madison Avenue.

By the summer of 1984, he told a reporter, Personal Best was spending $36,000 a week on advertising — $1.8 million a year — and grossing $150,000 a week. "The Personal Best Center, properly staffed," he wrote in a draft of a franchising plan, "is basically a money machine fueled by advertising."

Dombroff became a doctor with a "press secretary." He was featured in a Newsweek cover story about cosmetic surgery. He opened offices in Huntington, Beverly Hills and Palm Beach. He built a luxury house in Huntington and acquired a yacht, a Rolls Royce and a stretch limousine with a full-time chauffeur.

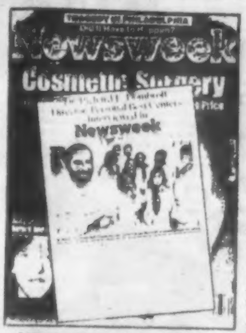
But behind all this success, there were problems. On July 20, 1982, two lawsuits were filed in state Supreme Court in Manhattan against Richard L. Dombroff. Both claimed Dombroff had committed malpractice against patients seeking hair transplants. One of these operations occurred just a few months after he finished his residency.

In the three years since, Dombroff and Personal Best have been served with at least 24 additional malpractice claims, by 19 different attorneys. Two of the suits have been dropped; the rest are in various stages of litigation. Dombroff's lawyers declined to discuss the cases.

An examination of court records and interviews with plaintiffs and lawyers in the 26 cases found by Newsday shows a pattern of allegations. For example, several plaintiffs said they were given little time with Dombroff before surgery and that he downplayed their post-operative problems. Several plaintiffs said they were embarrassed and asked that their full names be withheld.

L. Michaelson, a Manhattan resident, said she lost two months' work in 1983 after cheek-implant surgery left her with a severely bloated face and eyelids swollen almost shut. She said that when she returned to Dombroff to complain that she was in pain and the swelling wasn't going down, he gave her penicillin but said she was fine.

Michaelson said that when one side of her face began to discolor a few weeks after the surgery, she went to another plastic surgeon. He diagnosed a massive infection and admitted her to New York Hospital, where she remained for 10 days. He also found that the implants had been put in crookedly.



A promotional flyer used by Dombroff to display a Newsweek cover article on cosmetic surgery

The surgeon, Dr. Robert Corin, said in an interview that if the infection had continued unchecked "she conceivably could have lost sight from it." The infection, Corin said, most likely began at the time of surgery and should have been spotted within a few days. "She had a form of implant that tends to cause tissue reaction. With the best surgeons and the best technique there can be infections. The problem was that it wasn't recognized or treated. Can I say it was malpractice? I can't. Can I say I would be displeased if it were my practice? I certainly can."

Nasira Satcha, a former dancer from India, said she went to Dombroff in August, 1983, for removal of a lump of cellulite on one hip. But Dombroff, she claims, made surgical cuts along the entire length of the bottom of her buttocks. The result was "keloid formation," a condition common to dark-skinned people in which wounds heal with large, dark scars. A photograph displayed by Satcha's attorney, Edward Horn of Brooklyn, shows grotesque scars across the bottom of her buttocks — a possible result he says Dombroff should have warned Satcha about.

Another litigant, a Queens office manager, who asked that she be identified only by her first name, Phyllis, claims that Dombroff performed a breast augmentation that led to an infection and required two more operations in the spring and summer of 1984. After one implant became infected, Dombroff admitted her to New York Eye and Ear Infirmary and removed it. Later he inserted a new implant, but her breasts were now different sizes. She said Dombroff told her they would eventually be the same, but now, more than a year later, they remain different sizes.

"The scar is horrendous and the right breast is much larger than the left breast, which is the one he operated on three times," she said. "When I lift my arm it isn't round at the bottom like a breast should be. It is disfigured. When there's pressure on that side, like when I sleep, it's painful . . . He mutilated me . . . It is almost as if it's a factory he operates there."

Dombroff has contended that the number of lawsuits brought against him is small relative to the thousands of operations he has performed, and that some result when patients have unreasonable expectations. "The more cases you do, the more problems you are going to have, and I think we have damned few problems," Dombroff said earlier this year when fewer cases had been filed.

But some members of his profession disagree. "There are plenty of plastic surgeons who have performed eighty-five hundred operations and never been sued," said Dr. John Goin of Los Angeles, president of the American Society of Plastic and Reconstructive Surgeons. "No volume of surgery in my opinion would justify 16 suits in three years." (Newsday found 10 additional suits in court records after the interview with Goin.)

The nine physicians making up the state Medical Society's Insurance and Defense Board apparently agreed. On Oct. 1, 1984, they recommended to the Medical Liability Mutual Insurance Company, which is owned and operated by members of the medical society, that it cancel Dombroff's malpractice insurance. At the time, Dombroff had nine malpractice claims pending. The insurance company refused to divulge whether it canceled Dombroff's coverage, and it could not be learned who now insures him.

"It was a monkey trial attended by my competitors," Dombroff said of the defense board hearing. "By people in the field who resent what I am trying to do and want to see me out of business . . . They refuse to look at the total number of cases treated." Dombroff claims that Personal Best has treated more than 10,000 cases in less than four years, including 5,000 in 1984.

Largely because of the malpractice cases, the New York State Office of Professional Medical Conduct has an open investigation of Dombroff. The office would not divulge details of the inquiry, although an official described it as "a very big case," made complex by the number and types of complaints. Penalties, ranging from reprimand to license revocation, can be imposed against doctors after deliberations by the state office, a committee of physicians, the state health commissioner and finally the Board of Regents.

Dombroff's malpractice situation in New York has kept him from getting a Florida license, for which he applied more than a year ago. "We're still waiting for additional information on his malpractice cases," said Diana Hull, a spokeswoman for Florida's medical licensing unit.

And the New York County Medical Society's peer review committee has received numerous consumer-oriented complaints about Dombroff. On Feb. 7, 1985, the committee's vice chairman, Dr. Miriam Seborer, wrote him: "The members of the committee ask me to advise you that your name appears on our agenda far too often. Whatever the reason for these many complaints, the members of the committee urge you to address this problem as soon as possible."

Seborer and other Medical Society officials would not discuss their inquiry. "These things are usually handled diplomatically," Seborer said. "We will do it quietly. I don't want people to think the Medical Society is sucking its thumb on this."

"Let me tell you," Dombroff told Newsday, "the County Medical Society has not received so many complaints relative to the total number of patients I have treated. The fact is there is a very small number, and every complaint has been addressed forthrightly."

* * *

> *Dear Sir,*
>
> *I am a qualified plastic surgeon from India who came to this country recently. I was working for the past five years in U K in various surgical specialties including 18 months in plastic surgery. At present I am doing nothing applying for residency positions starting in July '84. I will be grateful if you could give me some kind of job in your center so that I can be of some assistance to you.*
>
> —Madan Mohan, in a letter Aug. 31, 1983, to the director of the Personal Best Center

Shortly after he wrote that letter, Mohan, 42, went to work at the Personal Best Center. And during the next year-and-a-half, according to employees and patients of Personal Best, he worked alongside Norberto Jurado, a Cuban who lived

Newsday Photo / [illegible]

Dombroff is prepared for a television appearance

in Union City, N.J., and Linda Choi, who lived in Manhattan.

None is licensed to practice medicine in New York State.

Seven people who have worked at Personal Best — including members of the surgical staff, a nurse anesthetist and several consultants — told Newsday that Mohan and Jurado performed surgery and that Choi administered anesthesia as far back as 1983. In addition, three patients who have filed malpractice suits against Dombroff identified Mohan, Jurado or Choi in court papers or interviews as having performed what the patients said were medical tasks during their operations.

According to employees, Mohan and Jurado left Personal Best in the spring of 1985. Choi left in September.

Mohan is the only one of the three who has even applied for a New York license, state records show. His application was filed in 1983, but he has not gained admission into a hospital residency program required for a license.

New Jersey records show that Choi was granted a license in that state on Aug. 31, 1984, long after she began working at Personal Best.

New York law holds that a licensed doctor commits professional misconduct and may lose his license if he is found guilty of "permitting, aiding or abetting an unlicensed person to perform activities requiring a license." The law continues: "Anyone who knowingly aids or abets three or more unlicensed persons to practice a profession . . . shall be guilty of a class E felony." Conviction on such a charge is punishable by up to four years in prison.

Mohan, reached at his home in Philadelphia, where he said he is unemployed, insisted he never did surgery at Personal Best. "I was just helping there," he said. "I was just setting up instruments." Later in the inter[illegible] Mohan said, "I used to see some patients. I [illegible] to take a few stitches." He said he was paid $300 to $400 a week.

In a telephone interview, Choi denied that she administered anesthesia at Personal Best. But she refused to say what her job was or to answer any other questions.

Jurado has been employed recently by a plastic surgeon who once worked for Personal Best. When reached at that doctor's office, Jurado hung up the phone.

Personal Best employees said Dombroff did not tell patients that other doctors — let alone unlicensed ones — were performing surgery, and was thus able to turn out an extraordinary number of operations and claim them as his own.

One former employee is Gloria Danielson, a nurse anesthetist with 20 years' experience. She said Dombroff hired her in September, 1984, and laid her off two weeks later when he couldn't meet his payroll.

Danielson told Newsday she saw Mohan, Jurado and Choi in surgery almost every day. "I saw Dr. Mohan do surgery," she said. "Sometimes Dr. Dombroff would come in and make the incision and Dr. Mohan would finish or do the rest of the case." She said she also saw Jurado operate: "Same thing. All kinds of eyes, noses, faces." And she saw Choi administer anesthesia "almost every day, four or five times. I was with her."

Danielson said she was not aware at the time that the three were unlicensed. "They were functioning as physicians," she said.

Former members of Dombroff's surgical team said he would routinely allow unlicensed doctors to complete his operations. "What happened," said one former employee, "was that he would start with one of these doctors as an assistant and in the middle of the surgery he would split." In plastic surgery, according to other doctors in the field, the end of an operation is as important as the beginning — sometimes more important — because it is crucial to camouflage or minimize scars resulting from closing surgical wounds.

In a malpractice suit against Personal Best, Milagros Horrego, 49, of Rego Park, said that after she had a facelift in May, 1984, Jurado removed her stitches. Unhappy about the scars she said resulted, she returned to the office for a second operation. "Jurado was the one who operated," she said in an interview. "He tried to correct the first operation. But this operation was worse."

She went for a third operation on Jan. 14, 1985. "This time, Dr. Mohan. They treat me very bad. Dr. Dombroff drew on my face with a pencil but after, I saw Dr. Mohan with me. He put something over my eyes so I couldn't see Dr. Dombroff was not there."

Two other malpractice suits make similar allegations. Susan Rosenberg of Cedarhurst said in a deposition that a short Oriental woman sedated her with several injections and intravenous fluids. She did not know the anesthesiologist's name but later identified Choi in a picture. When asked during his own deposition who had administered anesthesia to Rosenberg, Dombroff said, "It was either [illegible] registered nurse."

Rosenberg, who [illegible] that her maiden name be used, also testified that during her facelift surgery, while she was under local anesthesia, Dombroff left the operating room to take a telephone call and that another man, whom she could not identify, took over the operation. She said he did not answer when she asked several times when Dombroff was coming back.

In his deposition, Dombroff said he did not recall having left the operating room.

But Personal Best employees say that it was common for Dombroff to leave the operating room. "He would be sort of walking up and down the halls looking into all the operating rooms," Danielson said. "And he would come into a room and take a knife and correct something, take a knife from Mohan or Jurado or whoever else was operating."

Employees added that Dombroff often forced anesthesiologists to rotate among the five operating rooms. Danielson said: "When we give a drug to a patient, we are supposed to stay with that patient. But he wanted us to cover two or three patients and run from room to room and leave the patients unattended. That patient could turn blue."

Danielson and others also said that Dombroff sometimes did not wear a sterile surgical gown and gloves or scrub before surgery. "No gloves unless he was doing the initial incision," Daniel-

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An Examination of 'Personal Best'

—Continued from Preceding Page

son said: "But if it was in the middle of a case where he was just looking in to see why it was taking so long, then he wore no gloves."

A doctor who worked at Personal Best said: "When I asked for a sterile gown, they said, 'You're wasting money. Richard doesn't do that.'"

The frenetic atmosphere reflected the number of cases Personal Best's advertising was generating. Occasionally, Dombroff has employed licensed surgeons for short periods of time to handle the caseload. But "assisting" surgeons such as Jurado and Mohan, staff members said, were also key members of the team: they allowed Dombroff to regularly book more than 10 cases a day under his own name — an astounding number, other plastic surgeons said.

One Personal Best staff member provided a reporter with what the source said were pages taken from Dombroff's personal schedule book for the week of Jan. 21, 1985. They list 12 cases for Tuesday, 15 for Wednesday and 14 for Thursday. Of those 41 cases, the schedule book indicates, 12 were revisions of previous surgeries — nearly one out of three.

Other plastic surgeons said this is an unacceptable revision rate. Dombroff's response is that he is a conservative surgeon and will revise any work that does not satisfy a patient. He said he often corrects the work of other doctors.

The schedule for Jan. 23 included one $5,000 procedure including a facelift, necklift, eyelid surgery and nose surgery for which one hour was allotted. Between 9 a.m. and 4 p.m., there were also two nose surgeries, one upper-lid operation, one dermabrasion, one facelift and eight revisions of previous nose, face and breast surgeries.

"A face, neck, eyes and nose all in *one hour?*" said Dr. Gold, the regional plastic surgeons' society president. "Probably the world's record. I can just envision it as a roping event in a rodeo where the rider throws his hands up into the air afterward. It can't be done."

Gold said of the Jan. 23 schedule, "I think there isn't a surgeon practicing in the United States, or anywhere in the world, who could possibly carry an operative schedule like this and do justice to any of the procedures listed. It is potentially disastrous for the people being operated on."

Dr. Robert Cucin, a plastic surgeon who said he has treated several of Dombroff's ex-patients, said: "Richard is a brilliant businessman but as a physician, he doesn't practice the kind of medicine I'm comfortable with. It's a mill."

Dombroff denies that anyone else has done surgery under his name. He says the key to his volume is his remarkable skill and speed: "A breast augmentation takes me under half an hour. It's just a question of different levels of skill. It's just like Dave Winfield will go out year after year and consistently hat .300 or .350 where most major leaguers will never hat more than .240 or .250. They're all major leaguers and they all make a living at it. There's just a wide variation in talent."

Dombroff said it matters little that he is out of residency only four years. "I was born with that skill and ability," he said. "I don't think it is purely a matter of years of experience. It is also a question of talent."

Several doctors who have seen Dombroff's work disagree. "We were responsible for his training, which galls us no end," said Gold, a vice president of Long Island Plastic Surgery Center in Mineola, where Dombroff served part of his residency. "He was adequate. He was bright and well-trained but certainly not a stellar performer."

There is little question that Dombroff works hard. "Richard has always been a go-getter," Patricia Dombroff said. In medical school, she said, he worked for the Maryland Eye Bank, collecting eyes from morgues. "He got so many eyes that they had to change the fee structure and they gave him an award. He has incredible energy."

Another possible clue to Dombroff's surgical volume appears in a lengthy "Business Plan" Dombroff drew up in 1984 as a sort of manifesto of his plans to franchise Personal Best nationwide.

One section reads: "Our surgical staff, headed by Dr. Richard L. Dombroff, has developed a set of surgical procedures and techniques which when applied have markedly shortened operative time, simplified surgical procedures and shortened expected healing times. While these are not proprietary in nature, they are not widely known and not widely practiced. Dr. Dombroff has not published these techniques, nor does he intend to."

Two people who have worked on Dombroff's surgical staff said they saw no innovative techniques but that Dombroff often took shortcuts that speeded up surgery. They said it was not uncommon for patients to return dissatisfied and that other surgeons working part-time for Dombroff sometimes had to fix his work. "We called them Richard's Redos," said one staff member.

* * *

"Actual selling of surgical procedures in our centers will most ideally be performed by a professional selling staff, preferably female, and preferably an individual who has an in-depth background in cosmetic surgery, either as a previous patient or as an experienced staff member."

—From a "Business Plan" of Personal Best

Under the Personal Best system, a consumer is entitled to a free consultation. But not necessarily with a doctor. The first person prospective patients see is someone called a "consultant." It is her job to sell surgery.

Consultants are not medical professionals, but they explain fees and procedures and book the surgery. Their function is explained in Dombroff's "Business Plan." Though Dombroff did not circulate the plan, he gave a copy of it to a reporter. A section called "Sales Tactics," notes that consultants should be "professionally skilled in selling" and that their earnings "will be proportional to their level of sales."

Several former consultants told Newsday that for every 80 surgeries booked and paid in full, they got $500. Newsday obtained one memo written on Dombroff's stationery and signed by Cynthia Croft, his Manhattan office manager, endorsing a bonus for one consultant. The memo, dated Feb. 16, 1985, reads: "Approved for 80 incentives. On file in Madison office. Includes 2 [illegible]."

That consultant, who has since left Personal Best, told Newsday: "I got two or three incentive checks a month." She estimated that commissions accounted for nearly one-third of her salary and that she felt pressured by Dombroff to sell surgery: "I'd be working on a Saturday and he'd call and say, 'Okay, we've got to bring in $10,000 today.' Or his accountant called."

Pamela Dombroff said in an interview, "We never had an incentive system."

"One method of maintaining a high volume has been to keep fees flexible. A section of the business plan called "Pricing" explains that it is acceptable to "close sales even at a somewhat reduced fee. Our Park Avenue experience has proven that it is still financially advantageous from a profit standpoint performing given surgery either at $950 or $1,500. Since we do not deal in a manufactured product, it is essential that we run our operating rooms at full capacity even if a particular case is generating only 50 percent of the usual fee. (Half of the pie is better than no pie at all)."

Despite their lack of medical training, the consultants, according to the business plan, "will give in-depth information about various cosmetic surgery procedures, discuss and set price and graduate the patient to the care of a staff surgeon."

"It is reprehensible in the extreme," said Goin, the national society president in Los Angeles, "for a non-medical person, particularly one working on a commission, to see a patient, give him all the information and sign him up before he sees the doctor. A surgeon is a consultant. He is there to give the patient the benefit of his experience and not to sell him. From a malpractice standpoint alone it is extraordinarily dangerous, as well as being amoral."

Patients, including some of those suing Dombroff, claim they were given either cursory examinations before surgery or none at all, and that Dombroff and his staff misled them about the possible effects of surgery.

"There is no informed consent being obtained from these people, which is a dangerous thing," said Gary Pillersdorf, the attorney for one plaintiff, Lori Parmacienoury, who asked that she be identified by her maiden name. "You have to be told enough so that you can make an intelligent choice."

Parmacienoury said she went to Personal Best in the spring of 1984 for a breast enlargement. Despite her repeated insistence over a two-week period, she said, Dombroff did not examine her or discuss the size of the implant before surgery. On the day of the operation, she was led into an operating room after being assured again that the doctor would examine her.

In an interview she gave the following account:

A woman she identified as "Dr. Choi" began preparing her for an intravenous infusion. "Are you nervous?" she said Choi asked her. "You seem nervous."

"I feel very rushed," Parmacienoury said she responded. "I want to talk to the doctor before the operation."

"Don't worry," Choi said. "He'll talk to you before he operates on you. Do you need something to relax?"

Parmacienoury consented, but insisted on something mild.

"Just a little something to help you relax," she recalls Choi saying. But Parmacienoury felt that she was being too heavily sedated.

"I can distinctly remember fighting it," she said. "I was trying to to say I wasn't ready for the surgery because I hadn't spoken to Dr. Dombroff. But I couldn't."

Soon the surgery began. "My left breast was especially painful during the operation," Parmacienoury said. She started to shake uncontrollably, possibly a reaction to the anesthesia, she was told later. "The person on my left said, 'I can't sew her up right, she's shaking too hard.' At that point I was able to say, 'You're hurting me!' to which someone replied, 'Give her more.'"

Parmacienoury does not know who the speaker was, nor who was in the room. There was a screen in front of her face. After the operation, she demanded to see Dombroff but was told he was already operating on someone else. She never saw him that day.

Dombroff, who distributes complimentary letters from patients, says those who are dissatisfied make up a tiny proportion of the [illegible] patients his office has treated. "We have a patient satisfaction rate in excess of 90 percent, according to our internal studies," he wrote in a letter to Newsday. In September, he asked a 58-year-old man from Long Island to attend a meeting with a Newsday reporter, as an example of the many satisfied patients he has treated.

When the reporter called him a few days later, the man said he was embarrassed and asked that he not be identified in the newspaper. He said that in June he had gotten "a complete job — nose, eyes, chin, neck," and that he was very happy with the result. "What I went there for I achieved," he said. "I feel very thankful to my doctor. A lot of people said, 'You look great' and all of a sudden, Dr. Dombroff loomed as some sort of a god."

But the man said he had serious misgivings about some aspects of Dombroff's practice. When he saw a consultant, he said, "she was overly solicitous. No matter what I asked, everything would be fine; there were no reservations." As it turned out, he said, the recovery period was much more difficult than he was led to expect. "It was like a fairy tale, a sales job. I use it in my own business." He is a sales manager for a company that makes parts for lamps.

The man said he had bargained the consultant down from $5,000 to $4,000, and was told he could pay after the operation. He went to Personal Best for his surgery on June 28, 1985, and was on the operating table ready for anesthesia when Dombroff came into the room.

"'What is this business you're not paying 'til next week?'" he quoted Dombroff as saying. "All of a sudden he becomes angry. I'm not going to have anybody operating on me who's angry at me. He said he's angry at his staff. I told him I didn't bring cash. I said I have VISA, but I don't like to use it. He took the VISA card and he became pleasant."

The man said it troubled him that he was never examined before surgery and was given little time to recover afterward. "He didn't take my pressure, check my heart. I'm 60 years old," he said. "Afterwards, I was still groggy, and I was rushed right out of the operating room. I really feel there should be a post-operative recovery."

* * *

It's a stage setting. People think if you're on Park Avenue you're a big deal.

—*Richard Dombroff, on why he chooses stylish sites for Personal Best offices*

Dombroff, a large man with a meticulously trimmed beard and a commanding presence, says he wants to become "the IBM of cosmetic surgery." But in some instances, image has surpassed achievement.

The advertising tag line, "From New York to Palm Beach to Beverly Hills" appeared in September, 1984. But neither the Palm Beach nor the Beverly Hills office opened until six months later.

And more than a year after the Beverly Hills office was first advertised, no surgery has ever been performed there. It is staffed by a receptionist who works five hours a day and only takes messages.

In an interview, Pamela Dombroff said she and her husband have been unable to find a doctor they are happy with to run the Beverly Hills office. But Beverly Hills is still advertised on the window of the Huntington office.

Dombroff has also made exaggerated claims in public relations packets and press releases. One claims that "the Collagen Corporation recently named Dr. Dombroff as one of its select regional practitioners in recognition of his achievements and experience in the delivery of Zyderm Collagen therapy."

But the company, which manufactures and markets a natural protein that is injected under the skin to smooth it, said that Dombroff is one of 8,000 doctors in the United States who are trained in the use of Collagen. Maureen Brunner, the company's marketing director, said: "We didn't give Dr. Dombroff anything."

Another release, distributed in 1984 and 1985, announced, "Personal Best has recently reached an historic agreement with the New York City Health and Hospitals Corporation to fully endow a much-needed burn center at the Bronx Municipal Hospital Center at Jacobi Hospital."

But the Health and Hospitals Corporation said that although Personal Best had discussed an endowment with city officials, no agreement was ever reached. "I went and got a copy of that brochure," said Aida Alvarez, vice president of the HHC. "One part of it was really misrepresented. Dr. Dombroff knows that we know and that we don't like that."

* * *

Last spring, Richard Dombroff filed a multimillion-dollar slander suit against Daniel Kagan, a freelance writer who was preparing an article about Personal Best for Newsday. Dombroff charged that Kagan had defamed him during interviews he was conducting in the course of his reporting.

Soon afterward, a Newsday staff member was also assigned to the story. Dombroff met with that reporter in September, and told him he would consider a formal interview. At that meeting, Pamela Dombroff said that she was now the president of Personal Best and Dr. Ernest Kirchman, a board-certified, Harvard-trained surgeon, had become its medical director and chief surgeon. A promotional brochure with a photograph of Kirchman describes him as "Medical Director of Personal Best Centers nationwide."

However, Kirchman, who maintains two offices of his own, said in a telephone interview: "I am one of the doctors working there. I am a practicing plastic surgeon who is working there on a part-time basis. I am there a couple of days a week. [Dombroff] is definitely in charge. It's his center. He may have wanted to confer a certain seniority on me but it really doesn't reflect any policy decisions on my part."

In the weeks after the September meeting, Dombroff communicated with Newsday only through his publicist, Miriam Silverberg, and by letter. Ultimately, he directed correspondence to a Wall Street law firm.

In one letter to Newsday, Dombroff wrote: "Personal Best and Richard L. Dombroff have been the target of a vendetta which has included forgery and extortion, not to mention lies and fabrications on the part of these groups conspiring to destroy us. We have material evidence of this and we will be happy to supply you with it."

When Newsday asked to be supplied with the evidence, Dombroff responded in another letter: "We have material evidence for this which we will be presenting to the public in due course and in suitable form."

During this time, two former employees told Newsday that Dombroff had fired them and refused to pay them money they were owed unless they agreed to sign statements saying they were "never aware directly or indirectly of any improprieties committed by Dr. Dombroff or others."

The statements, which were not sworn, said the employees never saw or heard about unlicensed doctors performing surgery, that they were never paid bonuses for booking surgery, that they always saw Dombroff inform patients of the risks of surgery and that they never saw him rush through procedures.

"It's all lies," said one of the employees, who said she saw unlicensed doctors do surgery and that she was paid sales incentives. "Signing it was the only way I could get my money. Everything he made me sign that I didn't witness, I did witness." Although the statement says she was offered no money for signing it, the woman showed a copy of a check for $2,015.20 for back pay signed by Dombroff the same day as the statement.

In a letter to Newsday, Dombroff wrote: "Contrary to what a handful of disgruntled ex-employees and a minute number of dissatisfied patients would prefer to believe, the record of Richard L. Dombroff and Personal Best is exemplary and it is the envy of the profession as a whole. It is precisely for this reason that we are being made scapegoats for all of the ills that plague American medicine today."

ARD J. COLLINS
INCORPORATED
Personal Best
COSMETIC SURGERY
COLLAGEN INSTITUTE
601 MADISON AVENUE

Newsday Photo / [illegible]

A doorman greets customers arriving at the Personal Best Clinic in Manhattan

medical economics
FOR SURGEONS

WHY 80 PATIENTS ARE SUING THEIR PLASTIC SURGEON

Their surgery results just didn't live up to his extravagant advertising claims. At this rate, he may become the most-sued doctor ever.

By Mark Holoweiko

In the household where he grew up, plastic surgeon Richard L. Dombroff always had a sense "that we had a greater destiny than others, that the usual path for other people wasn't right for us. I think it was similar, without being pretentious, to the Kennedys'."

When he said that in 1984, at the zenith of his career, he may have felt he'd achieved that destiny. He was only 32, but already a multimillionaire.

Today, Dombroff is a convicted felon who has served jail time for turning his practice into a con game based on false advertising. He has filed for bankruptcy. He has surrendered his license to practice medicine. And, with 212 malpractice claims pending against him—at least 80 of which are already actual lawsuits—he has become probably the most sued doctor on earth.

Dombroff contends that this is a piddling amount of litigation compared with the thousands of cosmetic-surgery procedures he performed. And in fairness, he's been found liable in only one case, where the jury said he injured a young woman to the tune of $2.65 million. (On appeal, the award was reduced to $750,000.) He settled another case for $250,000. That's how the remainder are apt to be resolved: with substantial payouts by his malpractice carriers, but no admission of liability by him.

What sort of damage is he alleged to have caused? "A lot of people claim they've got excessive scarring," says Hal M. Hirsch, the attorney for Dombroff's bankruptcy trustee. Hirsch, who spent two years hammering out a procedure for settling the 212 cases in bankruptcy court, explains: "Dombroff appears to have had a tendency to take off too much skin, so that when he sewed it back together, it would pull terribly, and leave what plaintiffs' attorneys are calling 'railroad tracks.' There's a woman who had them across her stomach. She had a tummy tuck that didn't heal for over a year. It was infected. The doctors couldn't do anything because she didn't have enough skin on the rest of her body to graft.

"Some of these people feel as if they've been run through a mill," Hirsch continues, "and some of their injuries seem to reflect it. A woman who goes in to have her lower eyelids done ends up having her upper lids done instead, and so much skin is taken off that she can't close her eyes. A number of women go in to have breast surgery—reduction or augmentation—and they come out with misplaced nipples or no nipples. A girl's ears stick out like a leprechaun's, and she wants to look normal. But so much skin is taken off when they're pinned to the side of her head that her glasses won't stay up. A man gets a chin implant, and it gravitates to his shoulder."

Lawyer Michael B. Wolkofsky represents about 20 of the claimants. "The most common complaints involve rhinoplasties and breast implantations," he says. "Dr. Dombroff is not the normal malpractitioner, an honorable physician who makes a mistake. This guy is a perfect example of the problems the medical profession has in policing itself."

Indeed, organized medicine was aware of Dombroff almost from the beginning of this dismal affair. But the medical establishment was powerless to stop him, doctor after doctor told MEDICAL ECONOMICS.

To be sure, Dombroff had gotten off to a promising start: undergraduate education at Columbia College in New York, graduation from the Johns Hopkins University School of Medicine, internship and residency at New York Hospital-Cornell Medical Center, and an office on Park Avenue in Manhattan. But soon he veered off on a tangent.

Possibly one factor that altered his course was a moonlighting stint at a hair-replacement mill after his residency. Another was inclination: Dombroff was interested mainly in same-day cosmetic surgery, so he didn't do enough reconstructive work to get board-certified. A third was Uncle Sam's attack on the ethical restrictions on medical advertising.

As you may remember, an administrative law judge for the Federal Trade Commission declared in 1978 that the American Medical Association's ban on advertising was illegal. The FTC said the AMA rule had served to "deny consumers the opportunity to obtain the information they need to select a physician."

[illegible] budget would have been the envy of most hospitals. In two years, it grew to a staggering $1.5 million

That position became the law of the land, thanks to a Supreme Court decision in 1982. And nowhere would its flaws be more obvious, or more ironic, than in the case of Richard Dombroff. That same year, he began spending $1,000 a week to advertise.

Hyperbole fuels a booming business

Dombroff called his practice "Personal Best" (after the title of a movie). His promotional efforts were wildly successful.

By 1984, Personal Best was doing 5,000 operations annually. Dombroff leased the entire seventh floor of a building on Madison Avenue for $9,000 a month as a second office, while maintaining his original one on Park Avenue. In addition to the tony addresses, he had a doorman and provided a chauffeured limousine to take patients home after surgery, creating the impression of a first-class enterprise.

Reinforcing that image was saturation advertising aimed at making Personal Best a household name in metropolitan New York. Dombroff's ad budget would have been the envy of most hospitals, having increased nearly 30-fold in two years, to a staggering $1.5 million annually. It was far and away his biggest practice expense.

Most of this outlay bought TV spots featuring Richard's wife, Pamela, as spokeswoman. (She'd had a couple of surgical improvements herself, courtesy of Richard.) She offered listeners "a free consultation with our warm, caring, expert team." She claimed that "over 10,000 happy men and women the world over have found the Personal Best system of same-day cosmetic surgery the safe answer to big doctor bills and long hospital stays." Her tag line went: "From New York to Palm Beach to Beverly Hills, Personal Best will help you look your very best—your Personal Best. But honestly, only our address is expensive."

Dombroff and Pamela wrote the promotional hype themselves. Handouts also didn't spare the superlatives, asserting that Personal Best was "the most exciting concept in health-care delivery of this decade." A branch planned for Beverly Hills would be "the largest and most completely equipped outpatient surgery center in California." The methods used by Personal Best were "an embodiment of the team approach . . . [of] the Mayo Clinic." And the doctor (not long out of residency) "supervises a New York staff of approximately 50 professionals, and oversees approximately 30 cosmetic surgery procedures performed daily."

Of course, extravagant personal services are inconsistent with discount prices, but Dombroff flaunted the contradiction, perhaps as a way of beating his critics to the punch. He'd check into The Breakers—the exclusive Palm Beach, Fla., resort hotel—and announce that "cosmetic surgery isn't just for the jet set anymore"; anyone would be welcome at the local office he was planning to open.

Nor did Dombroff shrink from questions about his maverick approach to medicine. Referring to his advertising, he'd tell reporters, "What we've done is put the medical establishment on notice that cosmetic surgery is no longer an elitist activity." And comparing himself to John D. Rockefeller or Henry Ford, he'd brag that he'd "pioneered" the marketing of cosmetic surgery "to the masses."

By 1985, Dombroff was touting himself as "one of the most prominent cosmetic surgeons in the world." He engaged a lawyer who specializes in such things to build Personal Best into an international franchise. In detailing his plans, Dombroff wrote: "The Personal Best Center, properly staffed, is a money-making machine fueled by advertising." His stated goal was to become the IBM or AT&T of his field. "I hope one day to control at least 50 percent of the cosmetic surgery in the country," he was quoted by one publication.

Extravagant tastes consume the profits

"All he cared about was money," says one of Richard Dombroff's former office managers. "He'd hang around until it was accounted for, then grab the cash and run. Or, if he was in the city and I was at the new Huntington office [on Long Island], I'd have to bring the cash up to his house. Every night, all the money from all the offices went to the house."

How much? "It depended on how many people paid that day," she continues. "Anywhere from $2,000 to $40,000 or $50,000 a day." In fact, by Dombroff's own testimony, he grossed between $4 million and $5 million in fiscal 1984-85. In various news media, he pegged it as high as $8 million.

Whatever the amount, he and Pamela had no trouble spending it. They built a $1.3 million home in a stylish section of Huntington, N.Y. It was a six-bedroom contemporary set on 5.6 acres with a pond, regulation tennis court, 20-by-40-foot pool, and electric gates.

A sample of Dombroff's 1985 expenses gives some insight into his values: He was leasing eight luxury cars (for business and pleasure) at $9,000 a month—a Rolls Royce Corniche, a Jaguar XJS, a couple of Porsches, a Cadillac limousine and a De Ville, a Lincoln Continental, and a BMW. For another $2,600 a month, he leased a 43-foot Pearson cutter-rigged yacht that slept six and was called "Personal Best." His monthly bill for car phones ran between $1,000 and $3,000. For maid service, it was $550 to $1,650. But he was putting just $72.66 toward his student loan from Johns Hopkins.

"Richard spent like a drunk," says attorney Raymond J. Dumas of Lansing, Mich., who devoted much of 1985 to working on the Personal Best franchise plan. "His staff shuddered when he went out for lunch. It could be a $4,000 lunch: He might come back with a bag full of exotic smoking pipes, or a gold watch. He figured, 'All I'm spending is two surgeries.' It was a numbers game to him."

Malpractice claims invite scrutiny

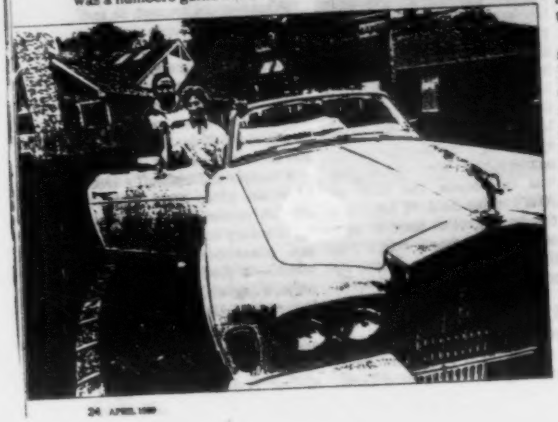
One published report says Dombroff was under investigation by the New York state licensing board as early as 1983 (before he'd been in practice even two years). The health department's Bureau of Professional Medical Conduct, which handles such investigations, refuses to confirm or deny this. As reasons for their silence, various representatives cite unfamiliarity with the case, memory problems, and the confidentiality of peer review.

But by law, the bureau must investigate every serious complaint against a physician. As of 1988, Dombroff had been hit with more than half a dozen malpractice suits. One plaintiff said Dombroff put her cheek implants in crookedly, then mismanaged a postoperative infection so badly that she had to be hospitalized for 10 days. A breast-augmentation patient, who also suffered a post-op infection, claimed that she underwent corrective surgery twice, but wound up with scarred breasts of different sizes. In the case that was ultimately settled for $250,000, a woman who'd wanted Dombroff to remove a bulge from one thigh was left with grotesque scars across the bottoms of both buttocks.

Evidently, some plaintiffs took their gripes to the licensing authorities, and an investigation was launched.

Before long, physicians began squawking, too. Vickie Silver, a New York lawyer who represents one of the early plaintiffs, says: "I've spoken to dozens of plastic surgeons locally who've heard of Dombroff, seen some of his surgeries, and were outraged by the results. A few told me that they'd reported him to the licensing board. They didn't like the way he ran his business like some sort of fast-food takeout."

Ditto, says Alan H. Gold, who



Dombroff and Pamela, at the height of success—before his indictment, before the Rolls was repossessed, and before she filed for divorce.

was president of the New York Regional Society of Plastic and Reconstructive Surgery from 1984 to 1985: "There were multiple complaints about him to the state medical board. He was being investigated for years, but nothing was done."

According to another knowledgeable source, Dombroff hampered—but didn't stop—the board's investigation by contesting its subpoena for some of his patient records.

Meanwhile, no one was trying to halt Dombroff's advertising. Back before the FTC stepped in, medical societies slapped doctors down if the type in their Yellow Pages listings was a tad too bold. But since then—afraid that a censured doctor might retaliate with an antitrust suit—organized medicine has been treading softly, no matter how flamboyant the ads.

Dombroff was a member of both the Medical Society of the State of New York and the New York County Medical Society. Neither organization would discuss the steps necessary to rein him in. But digging by MEDICAL ECONOMICS revealed what had been done.

In October 1984, the state society recommended that the malpractice carrier it had helped form—Medical Liability Mutual Insurance Co.—drop Dombroff as a policyholder because he had nine suits against him. The following May, MLMIC refused to renew his coverage. "There's a conspiracy by the New York state and county medical societies to drive me out of business," Dombroff protested. Scarcely skipping a beat, he then got a new policy from the Medical Malpractice Insurance Association, New York's joint underwriting association, which cannot refuse to insure a physician.

"He'd go in to do a nose, but he'd just cut her and move the nose around a bit. He didn't even try to fix things properly."

Equally ineffectual was the hospital where Dombroff sent most of his inpatients—New York Eye and Ear Infirmary—which didn't restrict his privileges. However, it's not clear whether the institution had any reason to do so, since he did the vast majority of his surgery in the office. For that reason, it would hardly have mattered even if he'd been kicked off the staff.

Since Dombroff wasn't board-certified, he couldn't join the American Society of Plastic and Reconstructive Surgeons, so that group couldn't have disciplined him if it had wanted to. However, some members of the regional ASPRS chapter assisted the licensing board investigation; others, like Alan Gold, debated him in the news media.

"The difficulty with a practice like his, built on advertising, is that it bypasses the checks and balances of the referral system," says Gold. "Patients don't choose the surgeon on the advice of their primary-care physician, or that of a friend or family member. They simply answer an ad.

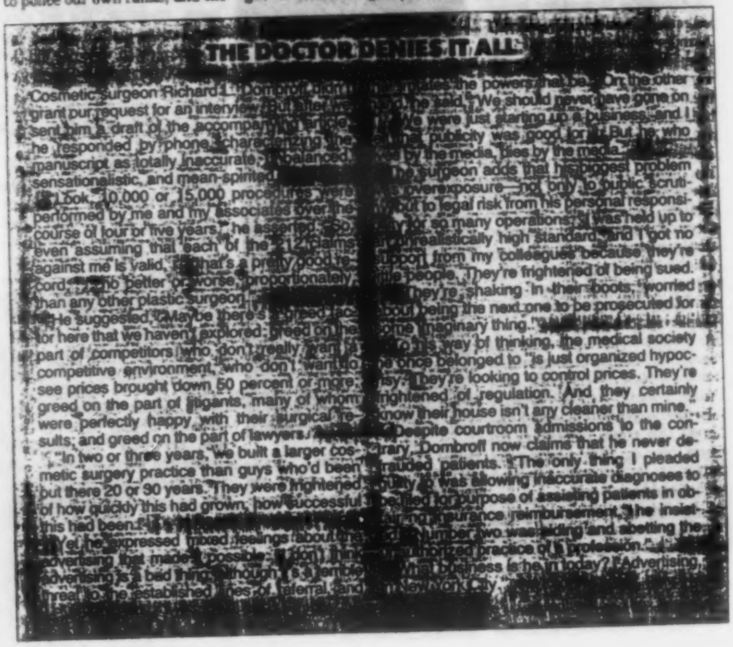
"And physicians who advertise a lot tend to be very liberal about whom they'll operate on. Somebody's got to pay for that huge advertising bill, so they stretch the indications for surgery until they've created a mill.

"While realizing that this was the nature of Dombroff's practice, there was nothing we could do except try to educate the public. We don't have the power to police our own ranks, and the state board is slow because it wants to assure everyone of due process."

The media take the scandal public

In November 1984, the public got its first real glimpse inside Personal Best. A feature story by free-lance writer Daniel Kagan in Manhattan, Inc. magazine used Richard Dombroff's own words to depict him as far more concerned about making money than about patients.

A few months later, Kagan



THE DOCTOR DENIES IT ALL

Cosmetic surgeon Richard L. Dombroff didn't [illegible] grant our request for an interview. But after we sent him a draft of the accompanying article, he responded by phone, characterizing the manuscript as totally inaccurate, unbalanced, sensationalistic, and mean-spirited.

"Look, 10,000 or 15,000 procedures were performed by me and my associates over the course of four or five years," he asserted. "So even assuming that each of the 212 claims against me is valid, that's a pretty good record—no better or worse, proportionately, than any other plastic surgeon."

He suggested, "Maybe there's a greed factor here that we haven't explored: greed on the part of competitors who don't really want a competitive environment, who don't want to see prices brought down 50 percent or more; greed on the part of litigants, many of whom were perfectly happy with their surgical results; and greed on the part of lawyers."

"In two or three years, we built a larger cosmetic surgery practice than guys who'd been out there 20 or 30 years. They were frightened of how quickly this had grown, how successful this had been."

Yet he expressed mixed feelings about the advertising that made it possible. "I don't think advertising is a bad thing, although it's a terrible threat to the established lines of referral and [illegible] irritates the powers that be. On the other hand," he said, "We should never have gone on [illegible]. We were just starting up a business, and I thought publicity was good for it. But he who lives by the media, dies by the media."

The surgeon adds that his biggest problem is overexposure—not only to public scrutiny but to legal risk from his personal responsibility for so many operations. "I was held up to an unrealistically high standard, and I got no support from my colleagues because they're [illegible] little people. They're frightened of being sued. They're shaking in their boots, worried about being the next one to be prosecuted for some imaginary thing."

[illegible] To his way of thinking, the medical society he once belonged to "is just organized hypocrisy. They're looking to control prices. They're frightened of regulation. And they certainly know their house isn't any cleaner than mine."

Despite courtroom admissions to the contrary, Dombroff now claims that he never defrauded patients. "The only thing I pleaded guilty to was allowing inaccurate diagnoses to be filed for purpose of assisting patients in obtaining insurance reimbursement," he insists. "[illegible] number two was aiding and abetting the unauthorized practice of a profession."

[illegible] What business is he in today? "Advertising, [illegible] in New York City."

began researching a follow-up article for Newsday, the main newspaper on Long Island. Alleging that Kagan had made defamatory remarks during interviews, Dombroff sued the writer for $11 million.

Kagan says the suit was intended to frighten Newsday into dropping the project. But Newsday stuck to its guns and provided Kagan with an attorney. Dombroff abandoned the claim in August 1985.

That month, the CBS News show "West 57th" revealed more of what went on behind the Personal Best facade. On camera, Dombroff claimed to be able to perform a rhinoplasty in 20 to 25 minutes, a face-lift in 45, upper and lower blepharoplasties in 40, and a breast augmentation in an hour.

Cut to a flabbergasted mainstream plastic surgeon sputtering, "I've never seen anybody do that—that kind of speed."

Cut to a woman identified as "Cathy" recounting how she went to Personal Best because "I was an A-cup and wanted to be a C-cup." Instead, she got seven operations interspersed with pain, infection, and episodes in which "there was gobs and gobs of blood and pus and mucus and all sorts of things coming out."

Newsday's exposé appeared in November 1985, shedding more light. It turned out that the "free consultations" at Personal Best didn't involve doctors. Potential patients merely got appointments with pretty young saleswomen (Dombroff called them "consultants") who earned a $10 commission on every procedure they booked. It wasn't unusual for a "consultant" to thereby boost her weekly income by $500.

The Newsday article documented that unlicensed foreign doctors were administering anesthesia at Personal Best, as well as completing operations after Dombroff made the initial incisions. Sterile technique was often breached because, in effect, the boss considered it a waste of time and money to scrub and don a clean gown and mask between procedures.

As the media scrutiny intensified, the malpractice suits mounted. Approximately 30 cases were pending against Dombroff by the end of 1985. Within a few months, the number of lawsuits would nearly triple. But the full scope of his scheme had yet to come out.

The doctor tries to cover himself

No one else may have realized it, but Dombroff clearly knew by 1985 that he was washed up. In August, when the "West 57th" segment was broadcast, he transferred to Pamela his half-interest in their home, his Personal Best stock, and the trademark rights. (The bankruptcy court took the house from Pamela and allowed it to be sold for the benefit of creditors.)

The same month, he closed one of the New York offices, and had outgoing workers sign statements "that during my employment at Personal Best, I was never aware directly or indirectly of any improprieties committed by Dr. Dombroff. . . . I always witnessed Dr. Dombroff fully inform each and every patient prior to surgery of the possible benefits and risks of each procedure. . . . I never witnessed nor was made aware of a situation or incident in which any non-licensed individual performed surgery, placed sutures, administered anesthesia. . . ."

In August, too, he purchased a business-protector insurance policy from Provident Life and Casualty Insurance Co.—purportedly through an agent friend of his. If he became disabled, Provident would pay him a monthly income of $50,000 to a maximum of $1.2 million. Three months later, Provident determined that temporal lobe epilepsy had rendered Dombroff totally incapable of performing surgery. The company now says it investigated further and after about six months stopped paying him.

Finally, Dombroff indulged in a bit of "good citizenship" that would eventually cause his downfall. He squealed to the Suffolk County district attorney on two terminated "consultants" for allegedly defrauding Personal Best's health insurance carrier. Specifically, he said Terry Hessel had falsely claimed to have undergone an operation at Personal Best in January 1985. The procedure had taken place a year earlier, before she was hired. And Margaret Wagner, Dombroff said, had forged his signature on a letter directing the insurance company to send Hessel the $2,850 reimbursement, which it did.

As his empires falls, the doctor is indicted

In January 1986, Pamela Dombroff served her husband with a complaint for divorce. It seems that Richard had moved in with one of his "consultants."

Because of supposed financial difficulties resulting from all the adverse publicity, his Rolls and Jaguar were repossessed, and he forfeited a $30,000 security deposit on one of his offices.

In February, Terry Hessel was told by a detective from the Suffolk County district attorney's office to surrender for booking on a charge of insurance fraud stemming from Dombroff's complaint. But her attorney persuaded prosecutors that "she had learned how to commit her insurance fraud from Dr. Dombroff's own continuing course of similar activity." In exchange for immunity from prosecution, Hessel agreed to testify against her old boss.

She informed police that patients usually paid in full before surgery, but afterward a phony claim with an inflated fee was often submitted to an insurance company at Dombroff's direction. Margaret Wagner backed up her story.

Armed with a search warrant, police raided the Huntington office and carted away nine boxes of medical and business records. Then the district attorney's office mailed questionnaires to 1,500 Personal Best patients, asking when they'd been treated, by whom, and how the bill was paid.

"We were inundated with hysterical phone calls," says Linda Spahr, the case prosecutor. "Hundreds of people were enraged at Dombroff. Some said they wanted to kill him. Others wrote us long letters about their experiences with him. But it wasn't until later, after listening to 50 or 75 grand jury witnesses, that I realized what the case was all about."

While she was putting the pieces together, more of Dombroff's cars were repossessed, and he was evicted from the Huntington office. The furnishings were set out on the sidewalk, where passersby helped themselves.

In April 1986, Irma and Jose Baez won a $2.65 million malpractice verdict—the only one against Dombroff so far. Mrs. Baez, a young mother of five, had gone to him in 1982 for a breast-reduction operation. She'd come away mangled, her breasts heavily scarred and misshapen. During trial, Dombroff conceded liability. In the end, the judge cut the award to $1.5 million, which still exceeded Dombroff's $1-million-per-incident coverage. The amount was cut to $750,000 on appeal.

Three days after the Baez verdict, he and Personal Best filed for a Chapter 11 bankruptcy (the kind where the business reorganizes and keeps going to pay off debts). Dombroff blamed his money woes on "inaccurate" negative publicity about his practice, and big debts incurred while trying to expand. "When all the facts are made known," he predicted, he would "be vindicated."

His bankruptcy papers showed assets of less than $50,000, and liabilities of more than $5 million. The mountain of debt included the original Baez award, but few of the 65 other malpractice claims he listed (since the damages hadn't been determined.)

Actually, more than 80 such suits were pending. His bankruptcy filing automatically halted action in all of them, and prevented any other patients from suing. (But they could still file claims against him with the bankruptcy court, and with his insurers.) Thus, the guy who'd aspired to be the IBM of cosmetic surgery had become its Johns-Manville instead.

Over in matrimonial court, a judge ordered him to pay Pamela support of $300 a week for their two children (who are now 11 and 9). Until brought into court on contempt charges, Dombroff ignored the order.

In June 1986, a Suffolk County grand jury indicted Richard and Pamela Dombroff. It charged them with a scheme to fraudulently separate patients from their money by promising high-quality surgery that the Dombroffs had no intention of delivering. Advertising created a false perception of Personal Best "as a nationally known, long-established, and professionally respected clinic."

The indictment went on to say that actually, patients didn't even get preoperative physicals, blood or urine tests, or a chance to speak with the doctor; often they underwent ghost surgery; "wholly untrained employees," such as the chauffeur, placed and removed sutures and prescribed drugs; and surgery was so overbooked that Dombroff sometimes had three patients undergoing surgery at once.

A former "consultant" adds: "We'd tell patients, 'Yes, you'll get exactly what you want.' We knew it was a lie. Dombroff would go in to do a nose, and the patient would say, 'I want the bump taken away.' But he'd just cut her and move the nose around a bit, that's all. She would come back because the bump was still there. 'Oh, it's because of the swelling,' he'd say. He didn't even try to fix things properly."

Why didn't more people go to the authorities? "Dombroff collected from them up front," she says. "Many couldn't afford the surgery, so he'd say, 'If you have insurance, I'll put it down so that insurance will pay for it'—so it appeared to be plastic reconstructive surgery, not elective cosmetic. It was fraud." And as accomplices, those patients weren't going to raise a stink, whether or not they got their money back.

The Dombroffs were also charged with aiding and abetting unlicensed practitioners, and with numerous counts of filing false insurance claims. Four others were indicted for the unauthorized practice of medicine: Linda Choi, Padinjarathara Madan Mohan, and Norberto M. Jurado, all foreign-trained but unlicensed doctors; and Joseph Salaska, a chauffeur/bookkeeper.

The doctor pleads guilty to fraud

As police escorted him and Pamela, handcuffed, to the county lockup, Dombroff told reporters: "We're fortunate to live in a democratic society. Justice will prevail." All the suspects pleaded not guilty. Bail was set at $50,000 for the doctor, $2,500 for his wife, and $1,000 apiece for the others.

Through his lawyer, Dombroff contended that virtually every aspect of the case against him was flawed—from the testimony of former employees and patients, to the conduct of the police and prosecutor. According to his 168-page motion to dismiss the charges, he was the real victim.

But the fancy footwork wouldn't enable him to waltz away scot-free. The three foreign doctors were facing up to four years in jail if convicted. In exchange for the district attorney's recommendation that they spend no time behind bars, they switched their pleas to guilty and agreed to help nail Dombroff.

Ultimately, in February 1987, Richard Dombroff pleaded guilty as charged to the felonies of scheming to defraud in the first degree, and aiding and abetting the unlicensed practice of medicine. Maximum punishment would have been eight years in prison. But because of a plea bargain, he was sentenced to three months in county jail, 1,350 hours of community service, and five years of probation—and was required to surrender his license to practice medicine in New York.

He also pleaded guilty to some professional-misconduct charges brought by the licensing board, which had assisted prosecutor Linda Spahr. These were such things as gross failure to manage infection in breast-enlargement cases, or to fracture the nasal bone when indicated during nose jobs.

At his sentencing in April 1987, Spahr characterized him as "motivated by greed, lust, and self-interest." According to the grand jury testimony of a Personal Best employee, she noted, Dombroff had once boasted, "I could sell cancer."

She said there was also testimony that "a patient was screaming from pain while being operated on, and he said, 'Stick a sock in her mouth so the other patients don't hear.'"

Another woman underwent breast surgery at Personal Best several weeks after giving birth, while she was still lactating. "She ended up with emergency surgery by another doctor since this doctor [Dombroff] wouldn't respond to her cries for help," Spahr said.

In yet another case, she continued, a woman "had collagen

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injections in her eye by a young clerk who had absolutely no medical training, who was acting on Dr. Dombroff's direction, and that woman has permanent damage to her eye now. . . . I think the evidence showed in the grand jury that this defendant did any kind of surgery on anybody, as long as they paid him money." For instance, she said, Dombroff would operate on diabetics without any special preparations, and, contrary to the usual practice, he'd do dermabrasion on dark-skinned people, and liposuction on anyone who could afford it.

"We believe firmly that this man should never touch a patient again," Spahr concluded. "The only way to guarantee that is [to let him cop a plea] because, unfortunately, the licensing system in this state at times has no teeth." Also, she wanted to spare patients the embarrassment of testifying about extremely personal matters at a highly publicized trial.

Pamela Dombroff pleaded guilty to the misdemeanor of scheming to defraud in the second degree, and was released without punishment. "She was kind of taken in by him as well," says Spahr. "She was kind of pathetic." The chauffeur confessed to the unauthorized practice of medicine. Like the unlicensed doctors, he was simply warned never to commit the crime again.

Bankruptcy sets off a feeding frenzy

The upshot? Dombroff's bankruptcy was converted to Chapter 7, in which the business goes belly up and the assets are divided among creditors. Although he didn't list it as such, the doctor had a tremendous asset in the form of malpractice coverage totaling $24 million. Plaintiffs' lawyers homed in: Today more than 100 attorneys of record are involved in the bankruptcy case, most of them representing malpractice claimants.

While that's a lot of money, it apparently isn't enough to compensate for all of the patient injuries. As U.S. Bankruptcy Judge Cornelius Blackshear put it at a hearing on the subject, "I think we all agree that the insurance coverage will not be sufficient to pay everybody 100-cent dollars."

"Coverage is at the bottom of it because the name of the game is money," responded one plaintiff's attorney candidly. If there wasn't enough, "What's the point of getting involved in all sorts of convoluted legal arguments? That's the time to sit down and start to whack up the pie."

And so they are, in what may be the most unusual malpractice settlements ever. The claimants will be segregated according to which of eight Dombroff insurance policies their injury falls under. (The maximum coverage under each policy is $3 million.) Each claimant will answer a set of interrogatories, be examined by a court-appointed plastic surgeon, and be photographed by a court-appointed photographer. Then they'll try to reach settlements with the insurers. When that doesn't work, a minihearing will be held solely on the issue of damages, which the bankruptcy judge will determine. Dombroff won't admit any liability.

Whatever the amount eventually paid to these plaintiffs, it's coming from the pockets of all the New York doctors who pay premiums to Dombroff's insurers. Whether there's any justice in that depends on whom you blame for the failure to clamp down on him quickly.

P.S. "In New York, a doctor can't permanently surrender his license," says attorney Diane Abeloff of the Office of Professional Medical Conduct. "One year from the date of surrender, he's entitled to apply for restoration of his license. Even if a criminal court said he must surrender his license forever, that 'forever' is only in effect for a year."

Apparently, then, the only thing that would prevent Dombroff from trying to return to medicine now—should he want to—is his five-year probation. He'd violate that if he applied before April 1992. ■

Twentieth Century Charlatans

They employed every new means of communication to promote their treatments. They hired professional promoters and publicity men. They utilized the press, the periodicals, and radio. They developed new business techniques. They received vast sums of money, and they spent it extravagantly in promoting themselves.*

One of the charlatans was Henry Junius Schireson, who claimed that he had attended the University of Maryland from October 1902 to May 1904, whereas actually he did not enter it until October 1903, and then he failed all his courses except histology and medical jurisprudence. He had attended one course of lectures in Maryland Medical College in 1905 and received a diploma in 1906.

In 1911 he came to Chicago and incorporated an office that advertised in foreign newspapers. The Illinois State Board of Medical Examiners refused to give him a license. In May 1912, he was arrested in Detroit because he obtained a license in Michigan on the basis of forged credentials. He removed to Pittsburgh where he ran an advertising office and paid protection to two county detectives. Here he was convicted, sentenced, and then pardoned after serving two months because he turned state's evidence. in 1914 he was arrested in New York City for practicing medicine without a license, and in 1915 he was sentenced to six months in the penitentiary.

In 1921 he obtained a license in Illinois during the incumbency of a director of that department named W.H.H. Miller who later was convicted of selling a million dollar's worth of licenses and who was fined $1,000. Schireson hired a press agent who later sued him for $50,000 charging that Schireson had never paid him adequately. The press agent asserted that despite his background Schireson had persuaded a number of notables including Fannie Brice and Lady Diana Manners to submit to operations. In 1927 Schireson got publicity in connection with an alleged surgical job on Peaches Browning.

Largely as a result of *The Journal of the American Medical Association's* efforts, in January 1930, Schireson was found guilty of fraud, conduct unbecoming a physician, and gross malpractice, and his Illinois license to practice medicine was revoked. After this, Schireson left Chicago for Philadelphia. There, toward the end of his career, he would attend society functions where he met women. Then he would send them presents of pedigreed dogs, the rearing of which was his hobby. Eventually some of the women drifted into his office, where he victimized them, utilizing the services of young men who had licenses to practice.

By 1937 so many judgments had been issued against him in behalf of former patients who had brought damage suits for malpractice that he pleaded bankruptcy. He was subsequently convicted of hiding $130,000 from his creditors. He was also convicted of perjury for testifying that he was not married and that he did not live in Merchantville, New Jersey. As a result he was sentenced to serve two concurrent terms of eighteen months in the Lewisburg federal penitentiary. His wife divorced him, and he died in the 1940s, almost penniless.

Another charlatan of plastic surgery was J. Paul Fernel, who was born Giovannie Furno. A native of Italy, he was graduated by the Illinois College of Medicine in 1911 and licensed during the same year. In 1919 Furno was in Detroit advertising treatments for "nervousness, manly weakness and any other blood disease."

In October 1919 Furno came back to Chicago, where he entered into an agreement with a Chicago "plastic surgeon" (of the advertising type) to be taught the art of removing sagging cheeks, baggy eyelids, hump noses, and wrinkles. While his preceptor was on a trip out of the state, Furno seized the opportunity to copy a list of the "plastic surgeon's" patients. On the return of the man from whom he was taking lessons, Furno discontinued his instruction and opened a competing office in Chicago. In 1920 his Illinois license to practice medicine was revoked, but two years later it was restored by W.H.H. Miller, the same man who had provided Schireson with a license.

Finally on December 29, 1944, Furno was sentenced to prison for three years following his conviction by a jury for violating the Food and Drug Act and for carrying on a mail-order business from his Chicago home.

Among the plastic surgeons was one named William E. Balsinger who sued the AMA in 1938 for $100,000, claiming libel. At the time several suits for malpractice were pending against him by patients on whom he had operated. Typical of the manner in which the exploiting plastic surgeon is consulted by people much in the news is the fact that both Balsinger and Schireson claimed independently that they were the ones who had done the surgery on the slightly battered nose of Jack Dempsey.

Abstracted from Morris Fishbein, M.D., An Autobiography. New York, Doubleday & Company, 1969, pp 47–50.

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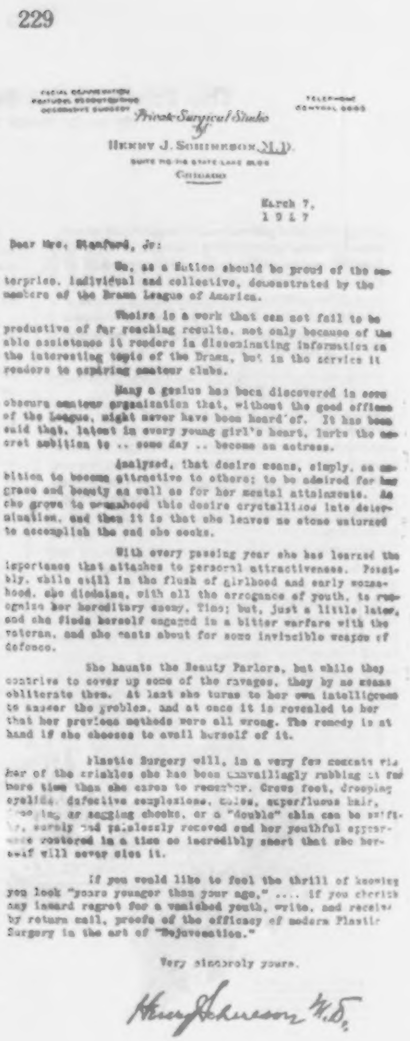
*Editor's Note: Déjà vu.

Editor's Note. The following letter taken from the files of the AMA requires some explanation. In the preceding article Dr. Fishbein describes the actions of some of the unethical practitioners of plastic surgery, mentioning Dr. Henry J. Schireson. This letter speaks for itself and was referred to AMA headquarters in Chicago for comment early in the twentieth century. It should be noted that Mrs. Stanford, Jr. never existed. Leland Stanford, Jr. died in 1884 in Florence, Italy, of typhoid fever at the age of 16. This editor is gathering material for a later publication on Dr. Schireson.



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March 7,
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Dear Mrs. Stanford, Jr:

We, as a Nation should be proud of the enterprise, individual and collective, demonstrated by the members of the Drama League of America.

Theirs is a work that can not fail to be productive of far reaching results, not only because of the able assistance it renders in disseminating information on the interesting topic of the Drama, but in the service it renders to aspiring amateur clubs.

Many a genius has been discovered in some obscure amateur organization that, without the good offices of the League, might never have been heard of. It has been said that, latent in every young girl's heart, lurks the secret ambition to .. some day .. become an actress.

Analysed, that desire means, simply, an ambition to become attractive to others; to be admired for her grace and beauty as well as for her mental attainments. As she grows to womanhood this desire crystallizes into determination, and then it is that she leaves no stone unturned to accomplish the end she seeks.

With every passing year she has learned the importance that attaches to personal attractiveness. Possibly, while still in the flush of girlhood and early womanhood, she disdains, with all the arrogance of youth, to recognize her hereditary enemy, Time; but, just a little later, and she finds herself engaged in a bitter warfare with the veteran, and she casts about for some invincible weapon of defence.

She haunts the Beauty Parlors, but while they contrive to cover up some of the ravages, they by no means obliterate them. At last she turns to her own intelligence to answer the problem, and at once it is revealed to her that her previous methods were all wrong. The remedy is at hand if she chooses to avail herself of it.

Plastic Surgery will, in a very few moments rid her of the wrinkles she has been unavailingly rubbing at for more time than she cares to remember. Crows feet, drooping eyelids, defective complexions, moles, superfluous hair, drooping, or sagging cheeks, or a "double" chin can be swiftly, surely and painlessly removed and her youthful appearance restored in a time so incredibly short that she herself will never miss it.

If you would like to feel the thrill of knowing you look "years younger than your age," .... if you cherish any inward regret for a vanished youth, write, and receive by return mail, proofs of the efficacy of modern Plastic Surgery in the art of "Rejuvenation."

Very sincerely yours,

Henry Schireson M.D.

The Truth About Beauty Surgery

By an Ex-Plastic Surgeon

Side by side with legitimate plastic surgeons, who have mastered their science, there fluorishes a band of surgical crooks, of all shades and complexions of quackery. Liberty [Magazine, *January 17, 1925, pp 4–6] has persuaded one of these beauty doctors—who for many years did a roaring business—to come out into the open with the secrets of his former trade. He has, of necessity, written this anonymously.*

The war had ended [1918] and plastic surgery was much discussed. I decided to learn it.

After a few years, in which I took something of a post-graduate course in this science—and I really did work conscientiously—I opened offices. I called myself a plastic surgeon rather than a facial surgeon. The reason was I wanted to delude people into ranking me with the men about whom people had read in connection with the reconstruction of maimed heroes and people mutilated by accidents.

I, of course, had to say I had learned it in Europe. For who wants anything new in science originating in this country?

Tell them that Doctor So-and-So of Paris or Berlin has done over the faces of the European nobility and that you learned your profession under him. Then watch the run on your office! Your instruments, of course, should bear foreign trademarks, and you must give out that they are especially designed for plastic surgery. In reality, only ordinary surgical instruments are used.

From the start business was brisk. I began advertising—not under my own name, but under that of an assistant—in theatrical magazines. Actors and actresses, who have to depend upon their appearances, are more interested in this type of work than any other class of people.

I operated on several stage people of note. From the standpoint of plastic surgery, these were simple little operations which had been known for years. But, through clever press agenting, I managed to have them heralded as new and unique.

My business swelled and fattened. I was visited at times by prominent society women and even business men.

It used to make me laugh when all these people, apparently well educated and thoroughly sophisticated, would sit back in open-mouthed amazement when I told them they could have their age lines removed, their ears and noses changed, and their mouths shortened or lengthened.

Not one of them ever thought of consulting some reputable surgeon and learning the aftereffects of cutting muscles—the risks and dangers they were taking.

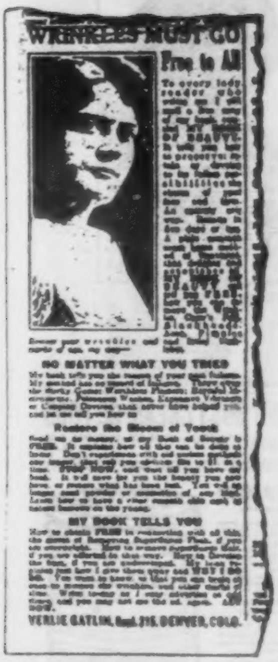
When I look back over my plastic surgical experiences there stand out in my mind innumerable facial "lifts." Every woman, it seemed, wanted a facial lift. It was one of the most popular operations.

I performed this little feat on a well-known actor. Word came to me afterward that he insisted I had not operated on him. I certainly had, but the scar simply did not show.

PEOPLE would sit back in amazement when I told them they could have their age lines removed and their ears and noses changed.

A Self-Confessed Faker Tells How He Has Fleeced and Sometimes Disfigured Hundreds of Women Who Came to Him in the Eternal Feminine Quest of Loveliness

Nostrums Circa 1900



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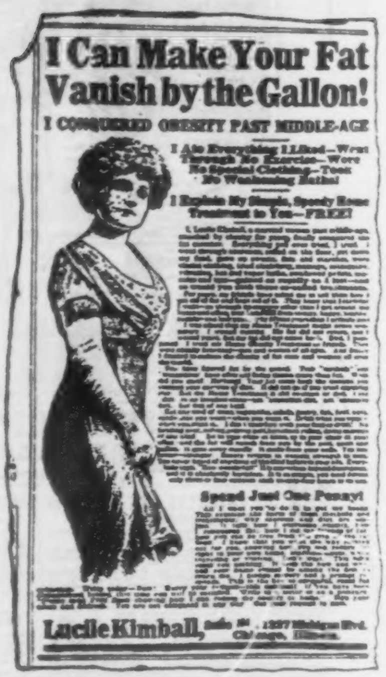
(From *Nostrums and Quackery*, 2nd ed. Chicago, American Medical Association, 1912, p. 70)



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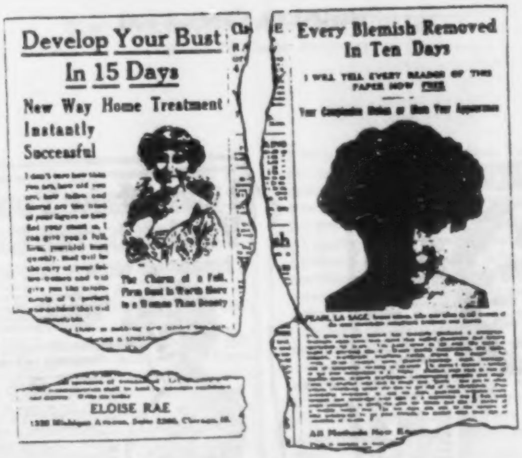

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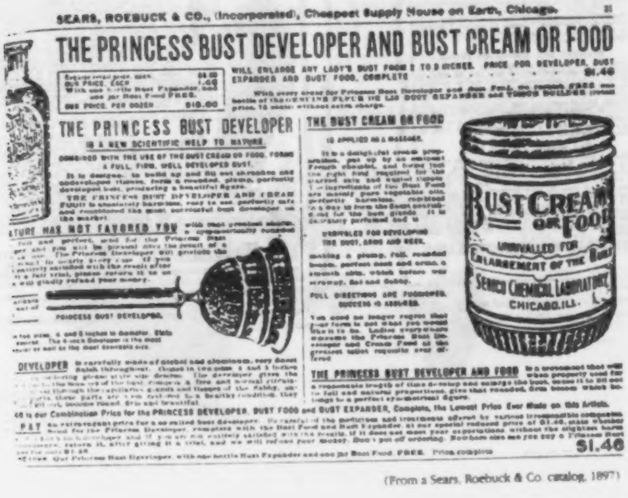
(From *Nostrums and Quackery*, 2nd ed. Chicago. American Medical Association, 1912, p 64)



SEARS, ROEBUCK & CO., (Incorporated), Cheapest Supply House on Earth, Chicago.

THE PRINCESS BUST DEVELOPER AND BUST CREAM OR FOOD

WILL ENLARGE ANY LADY'S BUST FROM 2 TO 3 INCHES. PRICE FOR DEVELOPER, BUST EXPANDER AND BUST FOOD, COMPLETE $1.46

THE PRINCESS BUST DEVELOPER

IS A NEW SCIENTIFIC HELP TO NATURE.

COMBINED WITH THE USE OF THE BUST CREAM OR FOOD, FORMS A FULL, FIRM, WELL DEVELOPED BUST.

ATURE HAS NOT FAVORED YOU

PRINCESS BUST DEVELOPER.

DEVELOPER

THE BUST CREAM OR FOOD

IS APPLIED AS A MASSAGE.

UNRIVALED FOR DEVELOPING THE BUST, ARMS AND NECK,

FULL DIRECTIONS ARE FURNISHED. SUCCESS IS ASSURED.

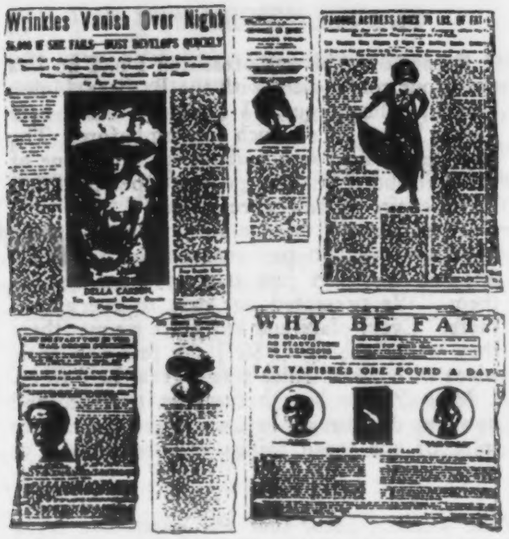
BUST CREAM OR FOOD
UNRIVALLED FOR ENLARGEMENT OF THE BUST
SEROCO CHEMICAL LABORATORY
CHICAGO, ILL.

THE PRINCESS BUST DEVELOPER AND FOOD

is our Combination Price for the PRINCESS DEVELOPER, BUST FOOD and BUST EXPANDER, Complete, the Lowest Price Ever Made on this Article.

$1.46

(From a Sears, Roebuck & Co. catalog, 1897)



Wrinkles Vanish Over Night

$5,000 IF SHE FAILS—BUST DEVELOPS QUICKLY

DELLA CARSON

FAMOUS ACTRESS LOSES 70 LBS. OF FAT

WHY BE FAT?

FAT VANISHES ONE POUND A DAY

(From *Nostrums and Quackery*, 2nd ed. Chicago, American Medical Association, 1912, p 391)

> Before our bill was presented I had no less than four conferences with the Barbers' Union here in Albuquerque. I can't remember ever having had to do so much fighting before. The argument waxed so hot about what our line of work included that it got into personalities. Then again politics were played. . . .
>
> Then our real trouble was to start—in the House. Over 50 per cent of the House is Spanish, and you just talk at them, not to them. We presented our case to every man there. Every place and any place we met them they were lobbied. [*Sic.*] A few had their wives with them, which was a great help to us.
>
> Miss Pinson has that go-get-it smile, and however discouraged we were, she smiled—in spite of the mean things that were said to us. . . .

What wonder, then, that the passionate legislators of New Mexico succumbed, and made cosmetology a licensed and learned profession!

3

Following the experience acquired by our surgeons in the Great War, plastic surgery advanced very rapidly. The need for restoring extensive segments of the skin, for rebuilding facial contours destroyed by explosives, and for repairing the ravages of burns by fire or chemicals gave birth to surgical methods with results nothing short of marvelous. Such specialists as the English surgeon

Gillies have published vast tomes recording the before and after aspects of hundreds of patients. A dissemination of the photographs marked "before" would make most potent propaganda for the pacifists. But the "after" illustrations, revealing the accomplishments of the surgeons, aided by certain artists in the creation of artificial noses, ears, toupées, and what not, arouse gasps of astonishment and almost of unbelief. However great the skepticism of the reader may be, the facts are nevertheless as depicted by Mr. Gillies.

A few regularly licensed medical men in some of our large cities have built up tremendous practices in such reconstructive surgery. Merely as an estimate, I should guess that there are to-day perhaps ten reputable surgeons in the United States who do any considerable amount of this work. In addition each of our large cities maintains from one to ten practitioners, all regularly licensed but beyond the best repute and wavering on the shadowy borderland of quackery, who likewise limit their practices to facial and body reconstruction. Finally, a considerable number of so-called general surgeons, of surgeons limiting their practice to the ear, nose and throat, and of physicians specializing in diseases of the skin undertake such procedures on occasion.

It is not within the purview of this article to define the marks of the charlatan in plastic surgery. Gradually those marks are becoming apparent even to credulous *Homo americanus*. Some of the "specialists" advertise openly in the newspapers, giving a list of the operations which they wish to undertake. An example follows:

> AMERICA'S LEADING
> FACE SPECIALIST
> AN ETHICAL SURGEON
> REGISTERED AND LICENSED
> OVER 22 YEARS IN
> CHICAGO, ILL.
>
> Many people do not realize that their facial appearance has so much to do with their success in business and society. It is true, your personality has much to do with your popularity, but even with a charming personality the entire effect is spoiled if you are embarrassed by a deformed nose of any kind. Sagging Cheeks—Nose to Mouth Lines, Ruffly-Wrinkly Skin over and under the Eyes—Scars—Outstanding Ears—too large or too small a mouth, a loose, flabby neck or any other deformity or blemish. For 22 years Dr. —— —— has been a Licensed Surgeon in Chicago, Ill. His knowledge gained from many years of study and his vast experience places him in a position to give you the soundest and most valuable advice just what can be done in your particular case.
>
> The corrections are done without loss of time from business or social affairs. No bandages are used and all the work is painless. Phone for appointment. Privacy is assured you at all times; separate entrance and exit.

The appeal to secrecy is one of the mainstays of the trade. The successful results are broadcast by the patient himself and by the charlatan through the press and through his advertising literature, but the patient who has had an unsuccessful result is likely, if he lives, to hide his chagrin in silence. Occasionally, when the results are especially serious, they come to light through the medium of the courts. From several hundreds of instances that are available I select a few:

> Los Angeles, Cal.—Suit for $500,000 damages has been filed here against Drs. —— ——— and —— ———, plastic surgeons, by Mrs. — — ———. In her complaint, Mrs. ——— states the defendants attempted to remove superfluous flesh from her ankles, but that it finally became necessary to amputate both legs.
>
> Chicago.—Dr. —— ———, plastic surgeon, . . . to-day is defendant in a damage suit for $7,000. . . . In her bill Mrs. ——— states that as a result of facial treatments a year ago her face was badly scarred and her eyes so badly crossed she was obliged to have them straightened by another surgeon "at great cost and suffering to herself."
>
> Chicago.—Dr. — — ——— is the defendant in a suit for $50,000, filed in the Superior Court yesterday. . . . The bill charges that on July 17, Dr. ——— performed an operation to straighten ———'s eyes. As a result of carelessness and insanitary conditions under which the operation was performed, according to the bill, ———'s eyes became infected and

it was later necessary for another surgeon to remove one of them.

A dignified, handsomely dressed woman walked into my office in Chicago in September, 1926. When she removed her hat and her veil her face revealed the wreckage of an encounter with one of the most widely advertised plastic surgeons in America. She had come to him only after Gillies, some French surgeons and several in New York had told her to avoid plastic surgery. But when she was a girl she had been operated on for removal of some glands in the neck and she considered the scar unsightly when she wore an evening gown.

The Chicago surgeon consented to remove the scar from the neck, inveigled the lady into a face-peeling operation, and undertook to do his surgery in his office under a local anesthetic. The results were pitiful. The caustic acid used in the face peeling had produced scarring worse than the original condition. The original scar had been operated on twice and as sometimes occurs in such cases, the new scars were far worse than the old. Portions of the eyebrows had been removed and the contraction of the scar had left an extremely distorted appearance.

Because of the prominence of her social position the woman could not go into court to seek financial reparations for the injury done to her body. The complaisant medical laws of the State of Illinois

34538
Pharmacy
Library

make it a haven for all practitioners who can gain a license since this valuable scrap of paper once obtained by hook or crook can be removed only on conviction of a felony.

One plastic surgeon who is reputed to be most successful—only, however, from the point of view of the size of his income—has for several years employed a publicity representative who is charged with the duties of securing patients of note, particularly in the theatrical profession, with the wide dissemination of news of successful results, with the suppression of newspaper statements about unsuccessful results, and with the promotion of publicity concerning unsuccessful surgery by and damage suits against competitors.

In many instances the records of these plastic surgeons are befogged by doubts as to whether or not they have ever had medical or surgical training sufficient to qualify them for undertaking the most simple of operations. Indeed, it is not clear in some cases that they have even graduated from reputable medical schools or obtained their licensure by proper examination. The aspirant for facial reconstruction will do well to inquire carefully into these matters before submitting himself to the scalpel.

The competent performer of plastic surgery gets his results by the transplantation of flaps of tissue from one portion of the body to another. The manipulation is delicate, usually demanding the retention of the original blood-supply of the part until a new blood-supply develops at the spot to which the transfer is made. Obviously here is a procedure to be carried out only in a good hospital and under the most aseptic conditions. The growth of such tissue may require weeks or months. Sometimes a portion of cartilage is transferred also, say to build up the sunken bridge of a nose that gives the face a dished appearance. The procedure of the charlatan is to fill a syringe with melted paraffin and to inject this beneath the skin to fill out the cavity. The paraffin hardens and the patient is satisfied. But experience has shown that paraffin has the peculiar quality of stimulating the growth of the tissue-cells, and numerous cases are now on record of the development of disfiguring tumors and even of cancers after its injection.

On a hot day in July in 1924 there came into my editorial sanctum a young woman accompanied by a somewhat elderly man. "Look at that nose," she said, and with the words demonstrated how the organ referred to might be turned right, left, upward or downward according to the direction in which her fingers impelled it. "Dr. —— did that," she said. "He promised me that he wouldn't use paraffin, and then when he got me in the chair he injected it. We've already paid him $300 for taking the bags out from under Joe's eyes, but this is terrible." And Joe, whose eyes still bagged a little, interjected: "I held the umbrella over her all the way over here so that nose would stay up until we got here." The lady had small chance of redress, for a complaisant State finds it difficult to interfere with the practitioners that it has once licensed, and the charlatans, anticipating difficulties, are protected by insurance companies which agree to fight their damage suits.

An especially rich field for the plastic surgery quack is the child or adult suffering from cross-eye. The majority of the cases are caused by eye-strain accompanying far-sightedness. Nowadays the eyes are first examined by a competent eye specialist and corrective glasses are tried before any operations are attempted. But the plastic surgery quack guarantees to cure by a simple operation, knowing that his guarantee is worthless. In more severe cases due to a deficiency of the muscles of the eye, surgeons who have specialized in the work will shorten a muscle or change its place of insertion. Each case demands careful study and accurate measurements which the plastic surgery quack is not competent to make and he can never obtain a competent eye specialist to help him. In several instances after enough patients have suffered the loss of an eye, State officials have been able to secure cancellation of the license to practice.

Cosmetic operations are most commonly sought by elderly women in love with young men, by aging actresses eager to continue profitably as ingénues, by women whose husbands have lost interest in them, by pugilists who have fought to financial success at the cost of facial continuity, and finally by foolish little salesgirls, stenographers, clerks, aspirants to the movies, sheiks, and what not. The most popular operation, perhaps, is that for the reconstruction of the nose, the most unsatisfactory organ ever devised by an all-wise Creator. The perfect heroine for novelists stands waiting: she is the impossible young woman who is perfectly satisfied with the nose that she was born with. There come then the correction of outstanding ears, the reconstruction of cauliflower or tin ears, the removal of "bags" beneath the eyes, the so-called face-lifting for the elimination of wrinkles or of jowls that have sagged, the excision of double chins, and, finally, the removal of fat, principally from the thighs, the hips, the buttocks, the abdomen and the breasts.

When these operations are performed by competent surgeons under the best of conditions the results are frequently successful—provided, however, (*a*) that there is no secondary infection, (*b*) that the tissues of the patient have sufficient recuperative power, (*c*) that the skin of the patient does not tend to the overgrowth of the scar tissue called "keloid," (*d*) that the accumulation of fat is not due to some inherent disturbance of the bodily processes particularly involving the glands of internal secretion, and (*e*) that the surgeon is lucky. Unfortunately, there are records of hundreds of cases in which the surgeons were *not* lucky—indeed, so many that reputable surgeons hesitate to undertake such procedures unless the defects are flagrantly disfiguring or involve a serious disability. During and after the war the government provided the wherewithal for stays of many months in hospital for soldiers undergoing repeated reconstructive operations. In the great manufacturing industries patients are sometimes severely injured through inadvertent contact with Frankensteinian machines, and it becomes necessary to rebuild features or to replace scalps that have been torn away. Great hospitals and funds are available for carrying on such surgical procedures. But only a few really competent surgeons find time or inclination for the type of plastic surgery performed wholly for esthetic reasons. That is the field which has been invaded and which is largely controlled by charlatans.

4

Somewhere toward the end of those vaudeville acts in which a young gentleman and a young lady indulge in acrimonious remarks relative to the merits of the sexes, the lady is likely to remark: "Well, in one way a woman is smarter than a man, anyhow." "What's that?" asks the feeder. "Well, you take a bald-headed man, he buys hair-tonic; but a woman buys hair."

The truth in the jest is apparent. The promotion,

Guest Editorial

Plastic Surgery and the FTC

Peter Randall, M.D.
President, The American
Society of Plastic and
Reconstructive Surgeons,
Chicago, Illinois

● In the August 1978 issue of the *New England Journal of Medicine* (Volume 299, Number 9, Page 478, 1978), Joseph C. Avellone, M. D., and Francis D. Moore, M. D., carefully outlined the development of the Federal Trade Commission's foray into the medical field. While discussing four areas of involvement (i.e., relative value fee scales, AMA policy on physician advertising, control of health-provider supply, and solo-practice physicians as inhibitors of HMO development), the authors remarked that much of the FTC's activity has been veiled in secrecy and enacted with a singular lack of medical consultation. As a result of the FTC's insistence on abolishing ethical norms in advertising, we are in the process of regressing some 75 years to the days of the exploitive, tasteless, high pressure ads. Most of these are in California and in the field of cosmetic surgery, though the practice is slowly metastasizing.

Not mentioned by Dr. Avellone and Dr. Moore was the current investigation of the American Society of Plastic and Reconstructive Surgeons, Inc. (ASPRS) by the FTC. This may well be far more dangerous and damaging than any of the others because it is clear that the action against our Society and Journal is a direct challenge to quality medical care, which, if successful, would apply to any specialty society and any specialty journal.

ASPRS has been singled out as a "trial balloon" testing the FTC's theory that *medical costs can be lowered if the quality standards of medical care represented by board certification are lowered.* Specifically, the proposed complaint, as originally drafted by the FTC staff, states that ASPRS has violated the antitrust laws by "maintaining unduly high standards for plastic surgery." Our reliance on board certification as a standard of competence is alleged to restrain unfairly physicians who are not board certified or board trained from practicing plastic surgery. The FTC proposal would force ASPRS to virtually ignore board certification as an essential measure of a physician's ability to practice the specialty.

In addition, the FTC would require our Society to de-emphasize board certification as a measure of competency to perform plastic and reconstructive surgery whenever questioned about the qualifications of any physician to practice plastic surgery. This de-emphasis is designed to downgrade board certification and equate all physicians claiming competence in this field.

Finally, the proposed order would infringe upon the rights of the editor of our Journal, the *Journal of Plastic and Reconstructive Surgery*, to select which advertisements and announcements will appear in the Journal. It is particularly distressing that the FTC will interfere with our Journal and yet refuse even to investigate the flagrantly deceptive advertising of some self-styled plastic surgeons.

In addition, the FTC would require our Society to de-emphasize board certification as a measure of competency. . . .

This action should be understood clearly for what it is—a venturesome and misguided effort by a lawyer-dominated bureaucracy to impose an untested theory in an attempt to lower costs in medical care. It also must be clearly pointed out that the victims of such a policy, if successful, would be our patients. They would be even more confused in trying to determine who is a competent plastic surgeon and who is simply calling himself a plastic surgeon, but in fact, may have little or no training or experience. The horrors inflicted on innocent victims by those who falsely profess competence in plastic surgery was reviewed

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Substantially the same material has recently appeared in the *New England Journal of Medicine*, but the editors believe that the importance of the subject, the timeliness of the article, and the stimulating form of its presentation justify presentation to the readers of *Surgical Rounds*.

last year on CBS's "60 Minutes."

One may ask how the FTC got into this field of medicine about which it is basically uninformed. The FTC was started in 1914 to protect the public against unfair competition in commerce. Its power has been expanded over the years to cover unfair and deceptive practices. And, just three years ago, Congress passed the 1975 FTC Improvements Act which greatly broadened the FTC's authority. Still, the so-called "learned professions" of medicine and law, for example, were generally considered to be beyond its jurisdiction until three recent Supreme Court decisions.

In the 1975 case of *Goldfarb v. Virginia State Bar*, a suit involving minimum fee schedules of attorneys, the Supreme Court held that the learned professions were covered by the Sherman Act and the fee schedules were abolished. Again, in 1975, in *Virginia Pharmacy Board v. Virginia Consumer Council*, the Supreme Court ruled that ethical restriction on price advertising by pharmacists violated the Sherman Act.

It is worth noting, however, that Mr. Justice Stewart, in his opinion in *Virginia Pharmacy*, cautioned against an interpretation of the law which would equate the commercial marketplace with the medical profession regarding advertising. He wrote:

> *the legislature is not dealing with traders in commodities but with vital interests of public health and with the profession treating bodily ills and demanding different standards of conduct from those which are traditional in the competition of the marketplace. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but protection against those who would prey upon the public particularly susceptible to the imposition through alluring promises of physical release, and the community is concerned with providing safeguards, not only against deception but against practices which would tend to demoralize the profession by forcing its members into an unseemly rivalry which would enlarge the opportunities of the least scrupulous.*

The so-called "learned professions" of medicine and law . . . were generally considered to be beyond its jurisdiction.

Nevertheless, in June 1977, the Supreme Court went one step further in *Bates v. Arizona State Bar* when it struck down the Arizona Bar Association's efforts to restrain solicitous advertising by attorneys of routine legal services.

The FTC staff jumped on the bandwagon of government action against the professions. As Jonathan E. Gaines, Assistant Director, Bureau of Competition, Federal Trade Commission, stated before the American Society of Association Executives on February 10, 1978: "Neither the nature of an occupation nor its public service aspect is enough to warrant exemption" [from the Sherman Act or FTC Act]. This attitude has been clearly reflected by formal FTC complaints against the American Medical Association, the Connecticut State Medical Society, the New Haven County Medical Association, and the American Dental Association, challenging the ethical standards on advertising which discouraged solicitation of patients.

As noted above, the FTC's efforts to abolish or weaken ethical standards of professional advertising are being done in the name of lowering the cost of medical care. Has it succeeded? Not in California. The bill of one such cosmetic surgeon for advertising in the *Los Angeles Times* alone (not counting other newspaper advertisements or his radio or TV ads) amounted to $123,000 in one year. Who pays for this? Obviously, the patient. Is he paying less for services? Again, in California, the charges by advertising so-called "plastic surgeons" vary between 30% and 50% higher than those of the board certified plastic surgeons in that state. But even more serious is the fact that considerable restraint should be exercised, particularly in the field of cosmetic surgery where so many cases are not well-suited for any kind of surgery and should be turned down.

Why has the FTC focused its attack on plastic surgery? We really can't be sure. The FTC has carried out an exhaustive study of many specialty boards and specialty societies. We know that there has been a small number of complaints from those without board certification in our specialty that denial of membership in our Society and alleged lack of access to our Journal for advertisements and announcements constitute an unfair restraint of trade. Although we do require complete certified training for Candidate membership and board certification for Active membership, we do have an Associate membership which does not require board certification. Furthermore, for many years, our scientific meetings have been open to all licensed physicians, as have our seminars, teaching sessions, publications, videotapes, audiotapes, films, etc. Also, with the current trends in medical advertising, plastic surgery does have what might be called a "high visibility" even though most of our members spend most of their time in noncosmetic surgery. Finally, our specialty is very small and perhaps more vulnerable to the staggering costs of federal litigation.

The FTC's appetite for more power has been clearly demonstrated by its recent efforts to persuade Congress to pass yet another "FTC Improvements Act"—vintage 1978. The proposed law was known as House Bill 3816 and, fortunately, was defeated just before Congress adjourned. Had this bill passed, and it nearly did, having attracted little attention from the medical profession, there are four devastating provisions which would have gone into effect. The bill, as originally proposed, would have allowed:

- Jurisdiction over *individuals* as well as *non-profit organizations* (such as the specialty boards themselves);
- Imposition of fines and penalties by the FTC *outside* of the traditional judicial system of the United States;
- Seizure of assets by the FTC of any individual or organization *prior* to filing a complaint;
- Placing the budget of the FTC (its life blood) and review of any of its decisions *outside of the review of the President of the United States.*

In regard to the action against ASPRS, we have continued to negotiate with the FTC and, as yet, a formal "order" has not been issued. If it is issued in its present form, we feel that we will have to resist it vigorously, but we will need help. We have already instituted a $400 assessment of each of our members practicing in the United States. One-third of this was paid within two weeks of the date it was due, and 80% within two months. However, these funds will be insufficient for the cost of lengthy litigation. Many of our colleagues have expressed concern and offered financial support, which we do not intend to ask for unless we are forced into litigation. I am anxious to know of any other interest or support.

While the FTC is trying to lower standards of medical care, it is interesting to reflect upon what Chief Justice Burger has said in respect to the importance of competence among professionals, particularly those engaged in specialized services:

> *. . . one of the most serious problems facing our profession . . . is the professional competence of those lawyers who come into the courts. . . . (W)e should see to it that those lawyers that come into the courts have at least the minimum acceptable competence. We can profitably look at the steps our medical friends took nearly half a century ago. They recognized the need to train physicians and surgeons separately, even though that separation was not rigid or absolute. Until we establish special standards for the right to appear in the courts, independent of admission to the Bar generally, we will not solve our problem. The needs of a modern courtroom can be analogized roughly to the needs of the modern operating room of the surgeon. In each situation, special training and skills are not simply desirable, they are imperative in the public interest. To treat a bare Certificate of Admission to practice law as a passport to try any and every kind of case in any court makes no more sense than to say that a medical school degree qualifies the holder to perform every kind of surgery. Our protection is that the hospitals will not let them do so.**

The FTC's appetite for more power has been clearly demonstrated by its recent efforts to persuade Congress to pass yet another "FTC Improvements Act"—vintage 1978.

Incompetence in the operating room or in any field of medicine is no less abhorrent. The victims, of course, are our patients, their lives, their appearance, and their ability to lead a normal existence. We feel this test case is of critical importance to all of medicine in that this ill-advised approach by the Federal Trade Commission has already done great harm and is very likely to do considerably more to our specialties, our carefully developed system of training, our specialty journals, and most importantly, to our patients. ■ ■

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*Chief Justice Warren E. Burger to the American Bar Association, February 12, 1978

ATTACHMENT B

ASPRS POSITION ON PHYSICIAN ADVERTISING

A. An advertisement should not name, or imply, ACGME approved training or ABMS member board certification in a specialty unless the physician holds those credentials.

B. When an advertisement includes the name of a specialty for which there is ACGME approved resident training, and the physician has not successfully completed that training, the advertisement must identify the ACGME approved training of the physician.

C. When an advertisement includes the name of a specialty for which there is an ABMS member board, and the physician has not been certified by that Board, the advertisement must name the certifying board, in full.

D. When an advertisement indicates board certification, if a physician has been certified by an ABMS member board, that board must be named if it differs from the name of the specialty or certifying board which is advertised, except where the certificate has been a credential for another ABMS member board certificate.

E. If an advertisement includes the name of a specialty for which there is no ACGME approved training, the advertisement must name the specialty of the ACGME approved training of the physician.

F. Additional bona fide training, certification, memberships, and self-designated interests may be listed, but may not be substituted for ACGME or ABMS credentials.

Approved
ASPRS Board of Directors
March 5, 1988

SUGGESTED ASPRS POSITION ON PHYSICIAN ADVERTISING

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E. If an advertisement includes the name of a specialty for which there is no ACGME approved training, the advertisement must name the specialty of the ACGME approved training of the physician.

F. Additional bonafide training, certification, memberships, and self-designated interests may be listed, but may not be substituted for ACGME or ABMS credentials.

Approved
ASPRS Board of Directors
March 5, 1988

CONCLUSION

The day for support of the pure interspecialty turf-battle is over. Quality care will survive in any marketplace. Let's continue the quest for expertise, recognize others who have it, and strive to protect the unwary consumer from FALSE AND DECEPTIVE ADVERTISING. Please take a close look at "Plastic Surgery: A Statement for the Eighties", recently approved by the ASPRS Board of Directors, and now available from the ASPRS Central Office. I believe it is a defensible approach to the NEW REAL WORLD.

ogress in plastic and reconstructive surgery; to promote the
ess of plastic surgeons as is consistent with the public

p is granted by the voting Membership of ASPRS to those
tent practitioners of the art and science of plastic surgery.
urgery involves attainment and maintenance of high
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the examinations of the American Board of Plastic
ience is fostered by the adoption and enforcement of a
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ers and the general public. Further, each member is
nd accountable for his own actions and words, as well as
hall be subject to disciplinary action, including expulsion,
General or Specific Principles of this Code.

rinciples
of the medical profession is to render services to
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the medical profession imply that the responsibilities of
only to the individual, but also to society. Activities
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n obtaining medical services, physicians should be
their services through advertising. Advertising, however,
hysicians may employ practices that are false, fraudulent,
Regulation is, therefore, necessary and in, the public

revocation of or a suspension by any domestic licensing authority.

B. He exhibits medical incompetence.

C. He is convicted of a felony or of any crime relating to or arising out of the practice of medicine or involving moral turpitude.

D. He is involved in improper financial dealings such as:
1. Payment and/or acceptance of rebates or referral fees.
2. Charging exorbitant fees, particularly of non-contractual nature (e.g., emergency care). Fees are exorbitant when they are wholly disproportionate to the services rendered. The reasonableness of the fees depends upon the novelty and difficulty of the procedures involved; the skill required to provide proper care; the time and labor required; the fee charged for similar services by similarly situated peers; and whether or not the patient had agreed in advance to the fee.
3. Except in instances of unexpected or urgent and life threatening disease or injury, nothing in this Principle shall be construed to prohibit a member from requiring prepayment of professional fees for an elective surgical operation.

E. He, on behalf of himself, his partner, or associate or any physician or other healthcare provider affiliated with him or his organization, uses or participates in the use of any form of communication containing a false, fraudulent, deceptive, or misleading statement or claim including a statement or claim which:
1. Contains a misrepresentation of fact, or omits to state any material fact necessary to make the statement, considered as a whole, not deceptive or misleading.
2. Contains images of persons or facsimiles thereof which falsely or deceptively portray a physical or medical condition, injury, disease, including obesity, or recovery or relief therefrom.
3. Contains a testimonial pertaining to the quality and efficacy of medical care if the experience of the endorser does not represent the typical experience of other patients or if, due to the idiosyncrasy and/or complexity of such care, results in other cases cannot be predicted with any degree of accuracy.
4. Is intended or is likely to create false or unjustified expectations of favorable results.
5. Contains a representation or statement of opinion as to the superior quality of professional services which is not susceptible to verification by the public or contains a statement representing that the member possesses skills or provides services superior to those of other physicians with similar training unless such representation can be factually substantiated.
6. Appeals primarily to a layperson's fears, anxieties, or similar emotions.
7. Contains, in reference to any matter material to a patient's decision to utilize a member's services, a representation of fact or implication that is likely to cause an ordinary prudent person to misunderstand or be deceived, or fails to contain reasonable warnings or disclosures necessary to make a representation or implication not deceptive.
8. Contains a prediction of future success or guarantees that satisfaction or a cure will result from the performance of the member's services.
9. States or implies that a member is a certified specialist unless he is certified by a board recognized by the American Board of Medical Specialties.
10. Concerns illegal transactions.
11. Is not identified as a paid advertisement or solicitation unless it is apparent from the context that it is a paid announcement or advertisement.
12. Relates to professional fees other than:
    (a) A statement of the fixed fee charged for a specific professional service, provided that the description of such service would not be misunderstood or be deceptive and that the statement indicates whether additional fees may be incurred for related professional services which may be required in individual cases, and
    (b) A statement of the range of fees for specifically described professional services, provided that there is reasonable disclosure of relevant variables and considerations affecting fees so that the statement would not be misunderstood or be deceptive, including, without limitation, an indication whether additional fees may be incurred for related professional services which may be required in individual cases.
13. Is intended or is likely to attract patients by use of puffery or exaggerated claims.

F. He performs an unjustified surgical operation or a surgical operation that is not calculated to improve or benefit the patient.

Excerpt from ASPRS Code of Ethics

APPROVED BY AMA HOUSE OF DELEGATES 6/20/89

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-89)

Introduced by:	Louis F. Alfano, M. D., Delegate American Society of Abdominal Surgeons
Subject:	Need for Standards for Truthful Medical Advertising
Referred to:	Reference Committee on Amendments to Constitution and Bylaws (Richard B. Tompkins, M. D., Chairman)

Whereas, The Federal Trade Commission has effectively barred the American Medical Association from establishing meaningful standards for medical advertising that is truthful, informative and not deceptive; and

Whereas, State and county medical societies are similarly barred from establishing or enforcing such standards with respect to their members; and

Whereas, State medical licensure authorities are similarly restricted; and

Whereas, The American public has been endangered by deceptive, untruthful medical advertising promising risk-free, pain-free out-patient treatment and surgery without loss of time from work, and results far beyond reasonable expectations; and

Whereas, Much of this treatment and surgery, particularly elective cosmetic procedures, is performed by physicians without specialized training in the procedures they perform and with inadequate facilities; and

Whereas, The Federal Trade Commission, while effectively barring private organizations from establishing and enforcing standards, does not exercise its authority to adopt and enforce reasonable standards for medical advertising; therefore be it

RESOLVED, That the American Medical Association request the Federal Trade Commission to conduct hearings, where interested parties may be heard, for the purpose of establishing Federal Trade Commission standards governing truthful, non-deceptive and non-misleading advertising.

Fiscal Note: $2,000

OFFICE-BASED SURGERY:
SOLUTIONS FOR THE FUTURE

Presented by

Robert Singer, MD

Member, Operating Committee

American Association for Accreditation of
Ambulatory Plastic Surgery Facilities, Inc.
(AAAAPSF)

June 28, 1989

Subcommittee on Regulation, Business Opportunities and Energy
Committee on Small Business
U.S. House of Representatives

INTRODUCTION

As plastic surgeons, our goals are to provide the highest quality patient care, while keeping costs reasonable. This latter mission is being fulfilled quite successfully as technology allows an increasing number of procedures that can now be performed in doctor's offices. However, as you have heard in my colleagues' testimony, the potential for substandard care is very real. It is apparent that national standards governing these office-based facilities are essential if our first goal -- patient protection -- is to be fulfilled as well.

Perhaps nowhere is this more true than in the specialty of plastic surgery. As physicians from a wide variety of fields rush to practice a specialty perceived as being fast-growing and lucrative, the doctor's office can become a haven that is free from outside scrutiny. It has and will be stated by others that attempts to regulate the facilities where plastic surgery procedures are performed, as well as the physicians who perform them, is no more than a "turf battle." If this "turf" concerns patient protection, safety, adequate surgical training, morality and medical ethics, then we agree, it _is_ a turf battle. However, this is the only turf with which the Amercian Association for Accreditation of Ambulatory Plastic Surgery Facilities is concerned.

Office-based surgery -- in this and all other specialties -- is largely unregulated. As my colleague, Dr. Truppman, mentions in his testimony, the Health Care Financing

Administration has only developed criteria for outpatient facilities located in hospitals or free-standing, multi-specialty centers. Yet our statistics show that 50 percent or more of plastic surgery procedures are performed in doctors' offices. We recommend that this appalling lack of quality control be remedied with the following actions:

1) Develop national standards governing both the office-based surgical facilities and the surgeons who practice there. These standards should consist of a core of generic criteria that are applied to all types of ambulatory surgery and cover patient monitoring equipment, emergency-response procedures, administrative policies, physical plant, etc. Physical plant is an area in particular need of special attention, since the existing Medicare requirements for facility design (sprinkler systems, ceiling height, etc.) are patterned after those applied to hospitals. Such standards are inappropriate and excessive when applied to office-based facilities, and increase the cost of care without boosting quality or safety.

In addition, a subset of specific standards for each surgical specialty should be developed to reflect needs and potential problems unique to particular fields. Both generic and specific standards should be tiered according to the type of anesthesia used by the facility, and the scope of procedures performed. They should also be updated periodically and require:

- On-site facility inspections at regular intervals.
- Assurance that the surgeons practicing there have

privileges to perform the same operations at a local hospital.

- Appropriate levels of non-physician staffing.
- Participation in a peer review and quality assurance program.
- Display and adherence to a patients' bill of rights.
- Thorough documentation on each procedure performed.

2) Require these standards to be enforced on a mandatory basis by existing, nationally recognized accrediting organizations, which have already developed excellent evaluation criteria and have accumulated an impressive track record. These organizations are:

- The American Association for Accreditation of Ambulatory Plastic Surgery Facilities, Inc. (AAAAPSF).
- The American Association for Ambulatory Health Care (AAAHC).
- The Joint Commission on Accreditation of Health Organizations (JCAHO).

Using those existing organizations to enforce standards for office-based facilities will avoid the necessity for additional bureaucracy, manpower and funds. In fact, licensure fees might actually provide additional income for the government.

To harmonize the efforts of these various accrediting organizations, an umbrella group such as the American College of Surgeons could serve as overall coordinator. The AAAAPSF stands ready to asist any such umbrella group, whether it be private or governmental, in developing accreditation guidelines. In fact, as Dr. Truppman mentions in his testimony, we have already made this offer to the American College of Surgeons. We have also worked successfully with Blue Cross plans in both California and Maryland, as well as private insurance carriers, and will offer this same cooperation to others.

If an office-based facility is found by any of these organizations to be deficient, surgery in that center should not be allowed.

3) Mandate peer review for physicians practicing in office-based facilities, whether through licensure or extension of Section 1832 of the federal law governing Medicare-approved centers. To date, HCFA has not applied this portion of the law to office-based surgery facilities.

Appropriate training for physicians practicing in these facilities must be defined and required, and they must be barred from performing surgical procedures in their offices until they have obtained corresponding privileges in an accredited community hospital.

4) Require malpractice insurance for physicians operating in their offices.

5) Ensure truth in advertising by requiring full disclosure of the sponsoring physician's formal training, certification and accreditation status of his or her facility.

6) Implement these mandates through national legislation and/or model statutes for states.

SUMMARY

The solutions I have outlined will protect the public to the fullest extent possible by assuring a safe environment, while at the same time containing costs for everyone involved.

We plead with you to help us return order to the currently chaotic and potentially dangerous state of cosmetic, office-based surgery. As the first professionally organized accrediting program established for these facilities, we encourage peer review, quality standards and accreditation for all ambulatory, office-based surgical centers.

ATTACHMENT FOR DR. ROBERT SINGER's TESTIMONY

ATTACHMENT I: ASPRS POSITION PAPER
FACILITY FEES FOR OFFICE-BASED RECONSTRUCTIVE SURGERY
ATTACHMENT II: ARTICLE BY ROBERT SINGER, M.D.
"ADVERTISING BY PLASTIC SURGEONS"
ATTACHMENT III: STATE STATUTE & REGULATIONS
A: MARYLAND
B: FLORIDA
C: TEXAS
ATTACHMENT IV: DELINEATION OF PRIVILEGES IN CANADA
ATTACHMENT V: REPORT FROM CALIFORNIA SOCIETY OF ANESTHESIOLOGIST
ATTACHMENT VI: ABMS/AMA APPROVED BOARDS
A: SEPTEMBER 17, 1984 CORRESPONDENCE
B: JANUARY 23, 1989 CORRESPONDENCE
C: REGULATIONS FOR APPROVAL OF EXAMINING BOARDS IN MEDICAL SPECIALTIES
D: OCTOBER 31, 1988 CORRESPONDENCE - SELF DESIGNATED BOARDS

AMERICAN SOCIETY OF
PLASTIC AND RECONSTRUCTIVE
SURGEONS, INC

POSITION PAPER *RECOMMENDED CRITERIA FOR INSURANCE COVERAGE OF* FACILITY FEES FOR OFFICE-BASED RECONSTRUCTIVE SURGERY

PREPARED BY **THE SOCIOECONOMIC COMMITTEE**
APPROVED BY **THE ASPRS BOARD OF DIRECTORS, NOVEMBER 1987**

The American Society of Plastic and Reconstructive Surgeons (ASPRS), a national medical specialty society, is the largest association of plastic surgeons in the world. Requirements for membership include certification by the American Board of Plastic Surgery. It is recognized by the American Medical Association (AMA) and the American College of Surgeons (ACS). As of this year, there are 2,996 plastic surgeons in the United States, and ASPRS is the umbrella organization which represents 92 percent of the eligible plastic surgeons. It serves as their primary educational resource as well as their voice in socioeconomic matters.

The Society has, for many years, been deeply concerned about the steady rise in the cost of health care. Through the actions of its Board of Directors, ASPRS has committed itself to the implementation of cost containment measures in the health care field. Specific efforts in this regard have taken the following three forms.

1. Appropriate Use of Office-Based Out-Patient Surgical Facilities

The ASPRS has encouraged the development and appropriate use of *office-based* out-patient surgical facilities and has initiated the development of mechanisms designed to ensure uniformity of quality and standards in such facilities. This is not only important for patient safety, but also contributes to a good result.

It should be noted that the original impetus for the development of office-based surgical facilities in plastic surgery was the fact that escalating hospital charges were making the total cost of cosmetic surgery operations prohibitive for a growing number of patients. Such facilities existed only a short time when it became apparent that many reconstructive procedures which had always been performed in the hospital, both on an in-patient as well as an out-patient basis, could also be performed with equal safety in the office-based operating rooms resulting in reduced costs to the patient and fiscal intermediaries.

According to research performed by the Free-Standing Ambulatory Surgical Association and reports published by the American Medical Association,[1] there is conclusive evidence that infection rates and other forms of morbidity are no higher, and in some instances, even lower, in office-based facilities attesting to patient safety.

Because of the newness of many of the *reconstructive* procedures which can be performed in such approved settings, facility fees had not been previously included in the submission of prior UCR charges for reconstructive procedures.

There is also sufficient documentation on the increasing trend to move patient care from the in-patient hospital setting to the out-patient department of the hospital and more recently, into the physician's office. It would appear to be counter-productive to restrict reimbursement of the institutional component for operation performed in office-based facilities, while recognizing the professional component as acceptable and reimbursable.

2. Accreditation

Increasing numbers of plastic surgery office-based facilities prompted ASPRS recognition of the need for an accreditation body to set acceptable and uniform *high* standards for safety and quality of facilities and to ensure that facilities were meeting these standards. In 1980, comparable agencies did not exist or were only in their formative stages so ASPRS provided funding to establish the American Association for the Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF).

The AAAAPSF developed rigorous and objective criteria for accreditation of office-based surgical facilities at three distinct levels (A, B, and C). The differences between A, B, and C level facilities are as follows:

Class A. Facility is certified for operations done under local anesthesia only, without the use of adjunctive drugs. The procedures performed in an A facility are usually limited to removal of relatively small lesions.

Class B. Facility is considerably more extensive and limited to use as operating rooms only. It is certified for any plastic surgery procedures which can be safely performed under local anesthesia with the use of pre-medication, intravenous sedation or disassociative drugs.

Class C. Facility is certified for use of general anesthesia and is equivalent to operating rooms in many hospitals. Examples of procedures commonly performed in B and C facilities include skin grafts and flaps, hand procedures, excision of large lesions, certain types of post-mastectomy breast reconstruction, and nasal septal surgery.

As of 1986, approximately 300 facilities have been accredited by AAAAPSF with the following accreditation levels: Class A, 5 percent; Class B, 63 percent; Class C, 32 percent.

It should be emphasized that none of the facility levels are certified for procedures involving entering major body cavities. All operations performed in AAAAPSF facilities are under the direction of a board-certified plastic surgeon. By the very nature of the three categories of office-based settings, there may be different facility charges for the use of each class of facility, and these charges may vary by locality and region.

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[1] Laurel L. Olson, *"Establishing Freestanding Ambulatory Surgery Centers,"* Monograph from Dept. of Hospital Standards & Procedures, Division of Professional Relations, American Medical Association, 1982.

3. Education

Through numerous scientific meetings, symposia and teleconferences, ASPRS members have received comprehensive and timely information on new technologies in plastic and reconstructive surgery. These newer technologies, in most instances, have eliminated the need for older, cumbersome, multi-stage operations and have dramatically reduced the length of hospital stays.

It is the position of the American Society of Plastic and Reconstructive Surgeons that reimbursement of reasonable charges for facilities accredited by AAAAPSF, or other recognized and approved accrediting agencies, for *reconstructive* plastic surgery procedures can play a significant role in reducing the cost of health care in general. This is supported by the fact that on an average, 60 percent of the procedures performed by plastic surgeons are reconstructive, as opposed to cosmetic. It is recognized that over 50 percent of those reconstructive procedures can be safely performed in office-based facilities.

There has been a reluctance on the part of some third-party payors to provide reimbursement of office facility charges on the basis that to do so would cause an increase in the totality of health care costs, even though the cost on an episodic or unit basis would result in cost savings. To date, there are not any studies which support such a restrictive thesis. There is however, ample evidence that office surgery is less costly on a case-by-case basis for those procedures that can be safely performed in office-based facilities.

A growing number of large and respected third-party payors have amended their existing policies or liberalized their policy interpretations and are now providing reimbursement for in-office facility charges.

The latest figures supplied by *Blue Cross and Blue Blue Shield*, indicated that 42 Blue Plans had some type of agreement with physicians to perform office surgery.[2] Examples would include:

1. *Blue Cross and Blue Shield of Arizona* - instituted a statewide incentive program for office-based surgery. Physicians receive an additional 25 percent of their usual fee or $15 - whichever is greater - to perform 137 selected procedures in their offices.[3]

2. *Blue Cross of Greater Philadelphia* - has promoted ambulatory surgery for many years as a major element in its cost containment campaign. Overall, this campaign saved $15.9 million from ambulatory surgery alone in 1984.[3]

3. *Blue Cross and Blue Shield of North Carolina* - implemented an ambulatory surgery program for 18 selected procedures which saved its customers over $5 million in 1984. Individually, these 18 procedures had savings ranging from 45 percent to 81 percent compared to inpatient charges.[3]

4. *Community Mutual* (Blue Cross and Blue Shield in Ohio) - identified 24 surgical procedures which can be performed safely in a physicians office. Under the payment incentive program, the physician will receive an additional $25 or $50 depending on the procedure. During 1984, a study was conducted on the pilot program. Although there was only a 6 percent reimbursement rate - 263 incentives paid for 4,373 in-office surgeries performed - the study indicated that the pilot program saved $679,000 in hospital charges.[4]

Several insurance companies from the *private sector* have also studied methods of reimbursement for surgery performed in the office-based suit (Pacific Mutual, Mutual of Omaha, Aetna, Travelers and Metropolitan). The methodologies studied have varied somewhat but a common plan should evolve in the near future.

Medicare, as administrated by Health Care Financing Administration (HCFA), has not considered this issue formally but informal input has been stimulated by ASPRS and the dialogue continues. Congressional representatives, however, seem to be inclined to follow the lead of the private sector.

In September 1986 a paper authored by a representative of the private sector defined the cost advantages of surgery occurring in an ambulatory surgical facility.[5] It was presented at the meeting of the International Claims Association. It concluded that controlled reimbursement of expenses incurred for surgery done in an office-based surgical suite can conserve the benefits available on any plan. Ensuring that the surgeon is compensated for the traditional fee plus any valid overhead expenses will encourage more and better office-based facilities to be established.

Recommendation:

The American Society of Plastic and Reconstructive Surgeons recommends that the concept of adequate reimbursement of costs incurred in equipping, supplying and staffing office-based surgical facilities (commonly referred to as "facility fees") be adopted as policy by all fiscal intermediaries. The ASPRS and AAAAPSF offer their support in the development of such policy.

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[2] "Virginia Blues to Pay MDs for Office Surgery," *American Medical News*, February 7, 1985, p. 40.

[3] Mary A. Fruen and Marilyn J. Field, "Ambulatory Surgery Comes of Age," *Business and Health*, September, 1985, p. 27-30.

[4] *Comment* (Community Mutual), March 21, 1986.

[5] International Claims Association Meeting, September 1986.

ADVERTISING BY PLASTIC SURGEONS

Sir:

Several of my colleagues have asked that I put into writing those thoughts I verbalized at the annual California Society of Plastic Surgeons Meeting in Tucson (March 17 to 23, 1987). During this discussion regarding advertising, I acknowledged that the times and the marketplace have changed. Perhaps I am antiquated in my philosophies, but the resounding applause from my fellow plastic surgeons in that audience and additional comments following that session would lead me to believe that my feelings are more the rule than the exception.

I personally find advertising by individual physicians to be in poor taste. As plastic surgeons who desire to be perceived as fully trained, ethical, honest physicians, and a cut above those who are partially trained or self-proclaimed cosmetic surgeons, we must act professionally. I worked very long and hard to become a respected plastic surgeon, and I am proud of what I am and what I do. Each time I see an advertisement by a plastic surgeon I feel that my public image is tainted and compromised. Are we physicians and surgeons or just in the beauty business, no different from the hair stylists and cosmetologists or operators of tanning salons and cellulite centers. If we denigrate ourselves by advertising, I don't feel we are justified in viewing ourselves on that higher level. All we are doing is espousing meaningless rhetoric. Our image to our patients and our fellow physicians is compromised.

I keep hearing that the younger physicians are the ones demanding advertising programs. In fact, most of the advertising physicians have been in practice for over 5 years. The younger physicians are still concerned about their image, peer approval, and how they will be perceived by the community and hospitals. This is only a ploy of those who choose to advertise to justify their approach, claiming that through advertising they will be able to protect their and the younger physicians' market shares.

The best way to market our practice is by having satisfied patients. Our offices are the most effective marketing tools any of us have or need. Physicians should identify who and what they are and work on developing and projecting that image in their office and through their staff. Rather than spending a lot on ads, which upon closer scrutiny may have questionable cost-effectiveness, money could be better spent improving office ambience and upgrading the staff and delivery of care. A patient with a satisfactory experience, not just a good technical result, becomes a spokesperson for our capabilities, both visually and verbally.

Physicians are basically penurious. You cannot expect to take from a community without returning something to it. If a community has been good to you, you owe something in return. By expending the allotted budget of image-compromising advertisements on donations to various organizations, charities, and arts within the community, you not only better your community and improve the quality of life, but you also generate good will and a highly visible and positive image. That positive identity in the community will do more for the development of our specialty, and of a practice, than any ad. Remember that ads also have a negative aspect. Many patients find them unacceptable from a professional and would not continue to go to a person who chooses the route of advertising. If we are what we profess to be, we must act in that fashion and not be seduced by those few who have chosen to advertise. A few years ago that fringe group would have been viewed very negatively by the majority of plastic surgeons, not looked upon as marketing gurus. I don't think the times have changed that much, and I personally hope they never will.

Robert Singer, M.D.
9834 Genesee Avenue, Suite 100
La Jolla, Calif. 92037

ABSORBABLE GELATIN FILM: A USEFUL CARRIER FOR INTRANASAL GRAFTS

Sir:

Absorbable gelatin film can be a useful adjunct as a carrier for grafts of skin or mucosa in nasal septal surgery. Gelatin film has been used in the treatment of orbital floor fractures,[1,2] and a number of other applications have been described in orbital, nasal, and neurosurgical procedures.[3-5] We now wish to comment on what we believe to be another beneficial application.

Certain surgical procedures in the nose, such as the repair of nasal septal perforations, have at times frustrated even the most patient and accomplished surgeon. The surgical exposure can be difficult, the tissues are friable, and the long-term results can be disappointing. Techniques for septal perforation repair, such as local perichondrial or periosteal flaps,[6] as well as buccal sulcus flaps,[7] have been used successfully. In many instances, the addition of a free mucosal graft to provide a lining for the flap can greatly enhance the chance of a successful repair. The difficulty arises in securing the free skin or mucosal graft to the contralateral flap. Absorbable gelatin film is ideally suited for this purpose.

Absorbable gelatin film (Gelfilm) is made from denatured porcine collagen and is available in sheets 0.075 mm thick. When moistened, the gelatin film softens and becomes pliable while maintaining its structural integrity. A graft of skin or oral mucosa can be placed on the gelatin backing, which can then easily be affixed into its appropriate position either with nasal packing, a few sutures, or an appropriate adhesive. An adhesive particularly well suited for this purpose is Orabase, a pectin-containing oral protective paste which bonds both mucosal surfaces and moistened gelatin film.

Gelatin film carriers affixed with Orabase have been used successfully in patients undergoing nasal septal perforation repair. They also have been used as a protective splint for delicate mucosal flaps which might otherwise be vulnerable to injury. In addition, pieces of gelatin film were maintained abutting the nasal septum in normal human volunteers for up to a week with no discomfort. The technique of using gelatin film should prove to be useful for those surgeons who utilize either mucosal flaps or intranasal grafts.

Tad Wellisz, M.D.
David Ozerski, M.D.
Division of Plastic Surgery
University of Southern California
1200 North State Street
Los Angeles, Calif. 90033

REFERENCES

1. Raz, S. Gelfilm and blowout fractures. *J. Laryngol. Otol.* 90: 599, 1976.
2. Parkin, J. L., Stevens, M. H., and Stringham, J. C. Absorbable gelatin film versus silicone rubber sheeting in orbital fracture treatment. *Laryngoscope*

Pulse Oximeter in the Ambulatory Aesthetic Surgical Facility

Robert Singer, M.D., and Paul E. Thomas, M.D.

La Jolla, Calif.

One-hundred consecutive patients undergoing aesthetic surgical procedures with adjunctive intravenous sedation in an office-based ambulatory surgical facility were monitored by an anesthesiologist with an ECG, stethoscope, automatic sphygmomanometer, and pulse oximeter. The pulse oximeter detected hypoxemia occurring intraoperatively and in the recovery room earlier than the traditional methods of monitoring. By detecting early drops in the SAO_2 with the pulse oximeter, appropriate corrective measures could be instituted and titration of intravenous anesthetics adjusted, avoiding progression to more profound hypoxemia and thus resulting in the safer delivery of anesthesia. The pulse oximeter is a useful and recommended adjunct to the traditional methods of monitoring in an office-based ambulatory surgical facility.

The study was designed to evaluate use of the oxygen-saturation monitor (pulse oximeter) in patients undergoing aesthetic surgical procedures with adjunctive intravenous sedation in an office-based ambulatory surgical facility. The objective use of the pulse oximeter in this type of setting has not been previously reported in the plastic surgical literature.

Hypoxemia, insufficient oxygen in the blood, does not signify tissue hypoxia, but it should alert one to that possibility.[1] Intraoperative moderate to severe hypoxemia was reported in a series of patients undergoing aesthetic surgical procedures under intravenous sedation by Huang et al.[2] and by McNabb and Goldwyn,[3] while Vinnik,[4] Cunningham and McKinney,[5] and others have reported that no respiratory complications existed in their series.

This study incorporated the pulse oximeter to assess (1) if hypoxemia occurred in patients undergoing aesthetic procedures as outpatients in an office-based facility under intravenous sedation, (2) if there was a correlation between the traditionally monitored signs (blood pressure, ECG, respiratory rate, pulse rate, and clinical appearance) and the oxygen saturation values (SAO_2), and (3) whether the pulse oximeter was a useful tool in titrating levels of medication to prevent a progression of hypoxemia, if it existed.

MATERIALS AND METHODS

One-hundred consecutive patients undergoing a variety of aesthetic procedures, including facial (39 patients), nasal (27), and breast (34) operations, were evaluated. Patient ages ranged from 12 to 76 years. Each patient was monitored with the traditional ECG, automatic blood pressure device, precordial or pretrachial stethoscopes, and observation by a board-certified anesthesiologist. Additionally, a pulse oximeter was connected to the patient. Patients were monitored continuously throughout the operation and in the recovery room. The automatic blood pressure cuff was set to read blood pressure and pulse at 3-minute intervals, while the pulse oximeter updated the data with each heartbeat. All the patients were operated on by one author (Singer) and anesthetized by the other author (Thomas).

Anesthesia consisted of premedication with 10 mg Valium orally for adult patients or 25 mg Benadryl for children and teenagers. Patients were given intravenous sedation consisting of a combination of drugs administered by the anesthesiologist, including morphine, Demerol, Sublimaze, Inapsine, Valium, Versed, Vesprin, Brev-

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From the Section of Plastic and Reconstructive Surgery and the Department of Anesthesiology at the Scripps Memorial Hospital. Received for publication April 23, 1987; revised July 3, 1987.

Presented at the Annual Meeting of the American Society of Aesthetic Plastic Surgery, in Los Angeles, California, on March 23, 1987.

ital, or Benadryl, depending on the procedure and the patient's individual needs. Local anesthesia consisted of 2% Xylocaine with 1:100,000 epinephrine or, if larger volumes were used, 0.25% Xylocaine plus 1:400,000 epinephrine and 5% cocaine packs in nasal surgery. Patients were anesthetized to the level at which they became drowsy, cooperative, and free from anxiety and pain. That level varied with the patients as did the amount of medication necessary to achieve it.

Early in the study it became apparent that counting the respiratory rate, especially during the initial onset of anesthesia as well as while injecting local anesthetic, was not practical. If the SAO_2 began to drop precipitously, the patient was verbally stimulated regardless of his respiratory rate. If it continued to decrease, other techniques such as lifting the chin or insertion of a nasal or oral airway were employed. A Nellcor N-100 and an Ohmeda Biox 3700 pulse oximeter were used in this study. Changes in the blood pressure, pulse rate, and SAO_2 were statistically analyzed by the linear regression method. Hypoxemia was defined as the following:

No hypoxemia = SAO_2 95–100% = PAO_2 greater than 80 torr (mm's of mercury)

Mild = 89–94.5% = 60 to 80 torr

Moderate = 75–88.5% = 40 to 60 torr

Severe = less than 75% = less than 40 torr.

A reading of less than 40 torr represents the level at which the tissue's oxygenation capability is severely threatened.[1]

RESULTS

The pulse oximeter showed changes corresponding to the development of hypoxemia earlier than the traditional methods of monitoring. There was no correlation between the changes in SAO_2 and changes in the blood pressure, pulse rate, and ECG. The following graphs (Figs. 1 and 2) illustrate the random distribution of blood pressure and heart rate changes in relationship to SAO_2 values.

Blood pressure, pulse rate, and respiration were influenced by a variety of factors, including anxiety, pain with injection of local anesthetic, epinephrine uptake, discomfort, the effect of various intravenous medications, and bladder distention. Of these factors, only intravenous medication had an effect on the SAO_2. Thirty-nine percent (39%) of the patients exhibited no hypoxemia; 32%, mild (89–94.5% SAO_2); 28%, moderate (75–88.5% SAO_2); and 1%, severe (less than 75% SAO_2). This occurred even though the anesthesiologist was in constant attendance. However, hypoxemia was only transitory in nature, lasting 1 to 2 minutes in the majority of these patients. This usually occurred during the initial phase of anesthesia just before infiltration of local anesthetic. Upon seeing the decrease in SAO_2, the patients were verbally stimulated, resulting in their taking more frequent, deeper breaths, usually with a prompt return of the SAO_2 to normal limits. The amount of intravenous medication could then be titrated based on the SAO_2 to prevent a further drop, avoiding a progression of hypoxemia to a more profound level.

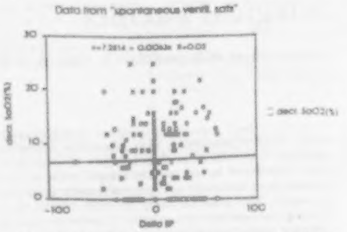

FIG. 1. A plot of the change in blood pressure in relationship to the decrease in SAO_2 in various patients during their procedures and in the recovery room. There was no correlation in the changes.

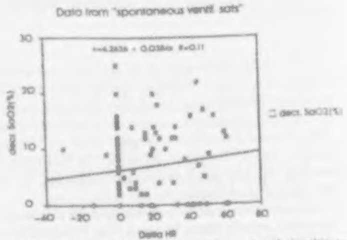

FIG. 2. A plot of changes in heart rate in relationship to decreases in SAO_2 in various patients during their procedures and in the recovery room. There was no correlation in the changes.

Mild hypoxemia lasting longer than 1 to 2 minutes occurred in 7 percent of patients; moderate, in 8 percent; and severe in 1 percent. An oral airway was inserted in two patients undergoing rhinoplasties, while a nasal airway was inserted in one patient undergoing a face lift, with prompt return of SAO_2 to normal limits in all these patients. Reversal of sedation with Narcan was not necessary in any patient, nor was supplementary oxygen, thus avoiding the concern of explosion or fire with the use of electrocautery.

The one patient who developed severe hypoxemia had a history of asthma. He underwent a rhinoplasty, septoplasty, and chin augmentation. In the middle of the procedure, the SAO_2 started to drop while vital signs and appearance were unchanged. Wheezing did not develop until the SAO_2 decreased to 60 percent. The pulse oximeter showed the onset of an asthmatic episode earlier than even auscultation. Intravenous administration of aminophylline resulted in a prompt return of the SAO_2 to normal limits.

Hypoxemia was seen more frequently during the infiltration of local anesthetic when maximum analgesia was desired, but it could occur at any time during the surgical procedure or in the recovery room. Its development was unpredictable based on the age of the patient (42.4 years arithmetic mean), length of the procedure, type of procedure, or amount of intravenous medication given.

DISCUSSION

The pulse oximeter is a noninvasive monitor that can be easily attached to the finger, ear, or toe. In most situations, the finger probe works best. Skin color and fingernail polish do not interfere with the monitor's accuracy. The correlation of SAO_2 as shown by pulse oximetry and arterial blood gases has been previously documented.[6,7]

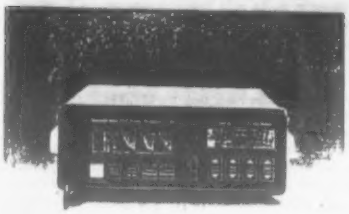

FIG. 3. A pulse oximeter.

An oximeter measures the absorption of selected wavelengths of light passing through living tissue samples. Oxygenated hemoglobin and reduced hemoglobin have markedly different absorption characteristics at 600 nm of red light and 940 nm of infrared light. These two light sources are contained in the probe, which is applied to a digit. The pulsation of arterial blood flow present in a particular test site modulates the light the oximeter's probe detects. Since other fluids and tissues present at the test site generally do not pulse, they do not modulate the light passing through the test site area. By using the pulsatile portion of the incoming signal, a microprocessor receives the data, converting them to a display of pulse rate and SAO_2 in percentage form.[8]

The monitor may not be accurate in the following situations:

1. A restless patient may dislodge the probe. The Ohmeda pulse oximeter has a mode that will note low quality of signal if this occurs or if there is poor placement of the probe.
2. Radio-frequency current from electrocautery may disrupt the signal strength to the monitor during cautery.
3. Dyshemoglobin species that are present, e.g., methhemoglobin or carboxyhemoglobin, may give an erroneous reading.
4. Any event that significantly reduces vascular pulsation will reduce the instrument's ability to calculate saturation. These include severe peripheral vascular disease, hypothermia, a patient with a constricted peripheral vascular system due to an extremely cold room, a blood pressure cuff being inflated on the same arm as the pulse oximeter, hypotension with a systolic pressure of less than 50 mmHg, and infusion of vasoconstrictor drugs.

A pulse oximeter has a significant advantage over a transcutaneous monitor in that it does not require a warm-up period. Additionally, it does not heat the skin under the probe, which may result in thermal burns during long operations. Dynamically, it updates the SAO_2 with each heartbeat, compared to the intermittent readings of serial arterial blood gases. Watterson stated that "vigilance monitors should be able to detect the problem quickly and specifically so that corrective measures can be initiated before irreversible physiological harm can occur." Hemodynamic monitoring with invasive techniques is inappropriate as a primary vigilance monitor in outpatient settings.[1]

Observation of the patient is a very imprecise method of determining hypoxemia. Cyanosis (the presence of 5 gm or more of reduced hemoglobin per 100 ml of blood) may not be overt until the SAO_2 falls to 65 percent. The perception of cyanosis is quite variable and a poor sign of early hypoxemia.

In 1981, Vinnik[4] presented a series of patients undergoing outpatient surgical procedures sedated with intravenous doses of Valium and ketamine. He stated that in all these patients respiration, blood pressure, pulse, and ECG were monitored. He concluded that "with careful observation of the patient and titration of the medication to clinical response, no respiratory or other problems had been observed." Cunningham and McKinney[5] reported no ventilatory complications in their 1983 series. In our present study, it was obvious that the traditional monitoring of respiration, blood pressure, pulse, and ECG was not effective in determining early hypoxemia. Measuring the SAO_2 with arterial blood gases or by the pulse oximeter, however, will show hypoxemia that would otherwise be undetected.

Presence of the monitor made the operating team and the anesthesiologist more aware of the possibility of hypoxemia, and its development was thereby avoided in many patients. If it did develop, the awareness of the decreased SAO_2 and the subsequent changes that were instituted helped prevent progression. In addition, the monitor was useful in determining whether the patient was anxious from oversedation or in fact from other factors, since oversedation with hypoxemia may cause anxiety.[10]

Hypoxemia also may extend into the recovery room. It is ideal to continue SAO_2 monitoring in that setting as well. When surgical stimulation ceases, the patient may become more sedated and hypoxemia may be seen. Patients are now routinely monitored with the pulse oximeter in the recovery room as well as in the operating room.

With use of the pulse oximeter and heightened awareness, the levels of hypoxemia seen in the series of Huang et al. (54 percent mild and 12 percent moderate in 24 patients undergoing rhytidectomy) and of McNabb and Goldwyn (mean PaO_2 of 74.2 mmHg in 20 patients undergoing face lifts or rhinoplasties) can be avoided, resulting in a safer delivery of intravenous sedation.

Robert Singer, M.D.
9834 Genesee Avenue, Suite 100
La Jolla, Calif. 92037

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Discussion

Pulse Oximeter in the Ambulatory Aesthetic Surgical Facility

by Robert Singer, M.D., and Paul E. Thomas, M.D.

Discussion by Bernard L. Kaye, M.D.

The pulse oximeter is a noninvasive, early warning, primary vigilance end-organ monitor whose availability was long overdue. Most systemic surgical problems start with hypoxemia, which is picked up immediately by the pulse oximeter. There is a significant delay (and exacerbation) of problems before they reflect themselves by changes in the ECG and blood pressure monitors.

Most of the pulse oximeters available at present incorporate a valuable auditory monitoring feature. Their auditory signals lower their pitch as oxygen saturation decreases, calling attention to decreasing SAO_2 values before they reach danger levels and set off lower-limit alarms.

I thoroughly agree with the authors' comment that observation of the patient is a very imprecise method of determining hypoxia. The day before drafting this discussion, I experienced a situation that strongly confirmed their observation. I was about to do a secondary procedure under general anesthesia on a patient who had undergone a noneventful primary operation 2 days previously. The anesthesiologist (the same physician who administered anesthesia previously) applied the pulse oximeter sensor prior to induction of anesthesia. He obtained a reading of 72 percent SAO_2. Because the patient showed no cyanosis, dyspnea, orthopnea, tachycardia, anxiety, or any other recognizable signs of hypoxia, he thought that he might have obtained a false reading due to a defect in the oximeter. He tested the pulse oximeter on his own finger, which showed an SAO_2 of 98 percent. Auscultation of the chest revealed moderate rales at both lung bases. Blood gases were then obtained showing a PO_2 of 43 and a metabolic alkylosis. A chest film was then obtained, which showed significant pulmonary congestion indicative of congestive failure ! The operation was canceled, and the patient responded rapidly to medical treatment. This is an example of a potential disaster averted by the early warning capacity of the pulse oximeter.

Use of the pulse oximeter is particularly helpful for patients having procedures under local anesthesia with sedation because of the hypoventilation associated with administration of sedative agents. Unlike the authors, who use nasal or oral airways to improve ventilation, I use a no. 10 French nasal oxygen catheter inserted at least 3 inches into the nasopharynx (to prevent possible problems with the use of cautery) and secured to the upper lip with a Steri-Strip. The pulse oximeter shows that this can increase SAO_2 by 4 to 5 percent. It also tells me when to ask the patient to take a few deep breaths.

I agree with the authors that the use of the pulse oximeter in the recovery room is at least as important as its use in the operating room. Sedated patients are more likely to hypoventilate during recovery without the stimulation of surgery.

The pulse oximeter is rapidly being adapted as a primary vigilance monitor, and with good reason. We are indebted to Drs. Singer and Thomas for bringing the importance of this instrument to our attention.

Bernard L. Kaye, M.D.
Suite 702
Laurette Howard Doctor's Building
Jacksonville, Fla. 32207

Received for publication June 19, 1987.

State of Maryland

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BOARD OF PHYSICIAN QUALITY ASSURANCE
4201 PATTERSON AVE • BALTIMORE, MD 21215-2299

Area Code 301-764-4777
TTY FOR DEAF: Balto. 383-7555
D.C. Metro 565-0451

April 25, 1989

Donald T. Moynihan, M.D.
Plastic and Reconstructive Surgery
570 Beachland Boulevard
Vero Beach, Fl. 32963

Dear Dr. Moynihan:

Thank you for your letter of January 19, 1989 to Patricia Carrington, who is no longer with our Board, regarding Physician Advesitising and use of the term "Board Certified."

Enclosed is a copy of our statute and regulations.

Sincerely,

Geraldine B. Bowman

Geraldine B. Bowman
Program Director

GBB/rt

Enclosure

Please address all correspondence to
P.O. BOX #2571, Baltimore, MD 21215-0002

MEDICAL and CHIRURGICAL FACULTY
of the STATE OF MARYLAND

1211 Cathedral Street
Baltimore, Maryland 21201
(301) 539-0872 • Toll Free 1-800-492-1056

SPECIALIST IDENTIFICATION: EXECUTIVE SUMMARY

In 1985, the Maryland General Assembly enacted legislation (SB 885) proposed by the Board of Medical Examiners and supported by the Medical and Chirurgical Faculty of Maryland, that prohibits physicians from identifying themselves to the public as specialists unless so identified by the Board of Medical Examiners.

Application for specialty designation is open to all licensed physicians in Maryland. If a physician is certified by the American Board of Medical Specialists (ABMS), the identification is automatically given by the Board upon confirmation of that credential.

If not certified by the American Board of Medical Specialists, the physician must complete an application outlining specific training and experience in the requested specialty. The applications are referred by the Board to a medical review committee (Committee on Specialist Identification) of the Medical and Chirurgical Faculty for evaluation and recommendation to the Board. Criteria used for such evaluations was developed jointly by Med-Chi and the Board and is set forth in administrative regulations (COMAR 10.32.08) which have the force and effect of law. The criteria is as follows:

1. The extent of training in the relevart clinical area or areas;
2. The length of time physician has been practicing the specialty or specialities;
3. The hospital activities and privileges as they relate to the specialty or specialties;
4. Continuing medical education courses attended in the last 5 years in the applicant's area of expertise;
5. Academic appointments in the applicant's area of expertise;
6. Quality of practice in the applicant's area of expertise as determined by peer review;
7. Membership in national and local specialty societies related to the applicant's area of expertise;
8. Whether or not the applicant's area of expertise, specialty or specialties is recognized by the American Medical Association or the American Board of Medical Specialties;
9. Recommendations for approved specialists as consultants in the applicant's area of expertise.

The Board makes the final decision on the basis of recommendations from the Med-Chi Committee. The identification is permanent, and the physician may publicize himself or herself in the given area of specialty.

SENATE OF MARYLAND

41r3419 No. 885 22

By: Senator Mitchell
Introduced and read first time: February 13, 1984
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 14, 1984

CHAPTER ________

AN ACT concerning

Physicians - Medical Specialties

FOR the purpose of prohibiting certain physicians from making certain representation to the public that the physician is authorized to practice a medical specialty unless the physician is identified as a specialist in that field by the State Board of Medical Examiners; providing that the Board may determine certain qualifications of a physician on request; providing that the Board may contract with certain groups for certain services; requiring the Board to adopt certain rules and regulations under this Act; allowing the Board to approve certain additional specialties that are recognized and approved by ~~national specialty certifying boards~~ certain organizations; providing for an effective date; and generally relating to medical specialties that the Board may authorize a physician to perform.

BY adding to

Article - Health Occupations
Section 14-704
Annotated Code of Maryland
(1981 Volume and 1983 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health Occupations

14-704.

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike-out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

(A) A PHYSICIAN MAY NOT REPRESENT TO THE PUBLIC THAT THE PHYSICIAN IS A SPECIALIST IN ANY FIELD OF SPECIALIZED MEDICAL PRACTICE UNLESS IDENTIFIED AS A SPECIALIST IN THAT FIELD BY THE BOARD.

(B) IF A PHYSICIAN REQUESTS, THE BOARD SHALL DETERMINE WHETHER THE PHYSICIAN QUALIFIES FOR BOARD IDENTIFICATION AS A SPECIALIST.

(C) (1) THE BOARD SHALL ADOPT RULES AND REGULATIONS CONCERNING APPLICATION PROCEDURES, FEES, AND REQUIRED QUALIFICATIONS FOR IDENTIFICATION AS A SPECIALIST.

(2) THE QUALIFICATIONS REQUIRED OF APPLICANTS FOR BOARD IDENTIFICATION AS A SPECIALIST MAY INCLUDE:

(I) THE REQUIREMENTS ESTABLISHED BY ~~VARIOUS NATIONAL SPECIALTY CERTIFYING BOARDS~~ THE AMERICAN BOARD OF MEDICAL SPECIALTIES, THE COUNCIL OF MEDICAL SPECIALTY SOCIETIES, AND THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION;

(II) EDUCATION;

(III) PROFESSIONAL EXPERIENCE; AND

(IV) WHETHER, BEFORE JULY 1, 1984, THE APPLICANT REPRESENTED TO THE PUBLIC, IN AN ETHICAL MANNER, THAT THE APPLICANT WAS A SPECIALIST.

(3) THE BOARD MAY CONTRACT WITH THE FACULTY OR ANY OTHER NONPROFIT AGENCY TO PROCESS APPLICATIONS FOR IDENTIFICATION AS A SPECIALIST.

(D) IN APPROVING ADDITIONAL SPECIALTIES, THE BOARD MAY CONSIDER THOSE FIELDS RECOGNIZED AND APPROVED BY ~~THE NATIONAL SPECIALTY CERTIFYING BOARDS~~ THE AMERICAN BOARD OF MEDICAL SPECIALTIES, THE COUNCIL OF MEDICAL SPECIALTY SOCIETIES, AND THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1985.

Approved:

Governor.

President of the Senate.

Speaker of the House of Delegates.

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Subtitle 32 BOARD OF MEDICAL EXAMINERS

Chapter 09 Identification of Medical Specialties

Authority: Health Occupations Article, §§14-205 and 14-704,
Annnotated Code of Maryland

.01 Scope.

These regulations govern the identification of a licensed physician as a specialist in Maryland by the Maryland Board of Medical Examiners.

.02 Definitions.

A. The following terms have the meanings indicated.

B. Terms Defined.

(1) "Board" means the Maryland Board of Medical Examiners.

(2) "Licensed physician" means a physician holding an active license issued by the Board to practice medicine in Maryland.

(3) "Limited practice" means having a special interest in or concentrating in any aspect of medical practice and representing to the public the appearance of medical specialization.

(4) "Medical review committee" means a committee appointed by the Board as set forth in Health Occupations Article, §14-601, Annotated Code of Maryland, to review applications for identification as a medical specialist either by specialty designation or by limiting practice.

(5) "Medical specialty" means a defined area of medical practice approved by the Board which connotes special knowledge and ability from concentrated effort or training in the defined area.

(6) "Peer review" means a process of determining quality of medical practice by a medical review committee.

(7) "Recognized specialty" means a specialty identified as a general certification in the annual report of the American Board of Medical Specialties (ABMS).

(8) "Recognized subspecialty" means a subspecialty identified as a special certification in the annual report of the American Board of Medical Specialties (ABMS).

(9) "Specialty board" means a board approved by the American Board of Medical Specialties which evaluates and certifies the physician who fulfills stated requirements for medical specialty certification.

.03 Qualifications for Identification as a Medical Specialist.

A. A licensed physician may apply for identification as a specialist by the Board if the licensed physician:

(1) Is certified by a specialty board;

(2) Has satisfactorily fulfilled requirements to attain eligibility to take the appropriate specialty board examination;

(3) Claims status in a specialty in which a specialty board certification examination and residency requirements exist, but who is not certified by the specialty board aporoved by the American Board of Medical Specialties, and who has not taken a full residency program, both of which were available at the time training was completed; or

(4) Claims to be a specialist or a subspecialist in areas in which there is neither a residency training requirement nor a specialty board certification examination.

B. A list of the specialties in §A is on file with the Board and will be provided upon request.

.04 Fees.

The Board has set a one time fee of $5 for each applicant for medical specialty identification. If applying under the provisions of Regulation .03A(3) and (4), an additional fee of $15 shall be submitted before reviewing the applicant's experience and education.

.05 Application for Identification as a Medical Specialist.

To apply for identification as a specialist, a licensed physician shall submit to the Board:

A. An application on a form provided by the Board;

B. An application fee; and

C. Evidence of qualifications to be identified as a medical specialist, including:

(1) Documented verification of specialty board certification,

(2) Verification of the successful completion of a Board approved specialty training program, or

(3) Description of education and experience that may qualify the physician for identification as a medical specialist.

.06 Identification as a Medical Specialist.

A. A physician may be identified as a medical specialist in the following two ways:

(1) If the licensed physician qualifies under Regulation .03A(1) or (2), above, the Board may approve identification as a medical specialist; or

(2) An application containing a detailed description of education and experience as described in Regulation .03A(3) and (4) will be referred to the Board's medical review committee.

B. Medical Review Committee.

(1) The medical review committee shall review applications and submit recommendations to the Board using the following criteria:

(a) The specialty area or areas being requested;

(b) The hospital activities and privileges as they relate to the specialty or specialties;

(c) The extent of training in the relevant clinical area or areas;

(d) The length of time physician has been practicing the specialty or specialties;

(e) Continuing medical education courses attended in the last 5 years in the applicant's area of expertise;

(f) Quality of practice in the applicant's area of expertise as determined by peer review;

(g) Membership in national and local specialty societies related to the applicant's area of expertise;

(h) Academic appointments in the applicant's area of expertise;

(i) Recommendations from approved specialists as consultants in the applicant's area of expertise;

(j) Whether or not the applicant's area of expertise, specialty or specialties is recognized by the American Medical Association or the American Board of Medical Specialties.

(2) The Board will make final determination as to specialty identification.

.07 Limited Practice.

Physicians may limit their area of practice and may so represent to the public only upon application to the Board for identification as a medical specialist under these regulations.

.08 Roster of Specialists.

The Board shall maintain a roster of all licensed physicians identified as specialists in each of the specialties recognized by the Board. The medical specialist shall keep the Board apprised of the medical specialist's current post office address.

.09 Reidentification as a Medical Specialist.

A. Identification as a medical specialist is permanent unless a physician:

(1) Has made false application;

(2) Requests in writing that the physician's name be removed from the roster;

(3) Has had the license suspended or revoked; or

(4) Has failed to maintain an active license.

B. Once removed, to be reidentified as a medical specialist, the physician shall re-apply for identification in the manner set forth in Regulation .05.

.10 Hearings.

A. If the Board disapproves an application for identification of a medical specialty designation, the Board shall provide written notice to the applicant of its determination and set forth reasons for denial.

B. Request for Hearing by Applicant.

(1) The applicant may appeal the Board's determination by making a written request for a hearing before the Board within 10 days of the receipt of the notice of disapproval of the application.

(2) The hearing shall be held within 60 days after the written request has been filed.

(3) At the hearing the applicant may be represented by counsel and may present witnesses and other evidence on the applicant's behalf.

(4) The hearing will be held in accordance with the Administrative Procedure Act, State Government Article, §10-101 et seq., Annotated Code of Maryland.

C. The Board shall affirm, reverse, or modify its previous determination and provide the applicant written notice within 20 days of the hearing.

.11 Prohibition.

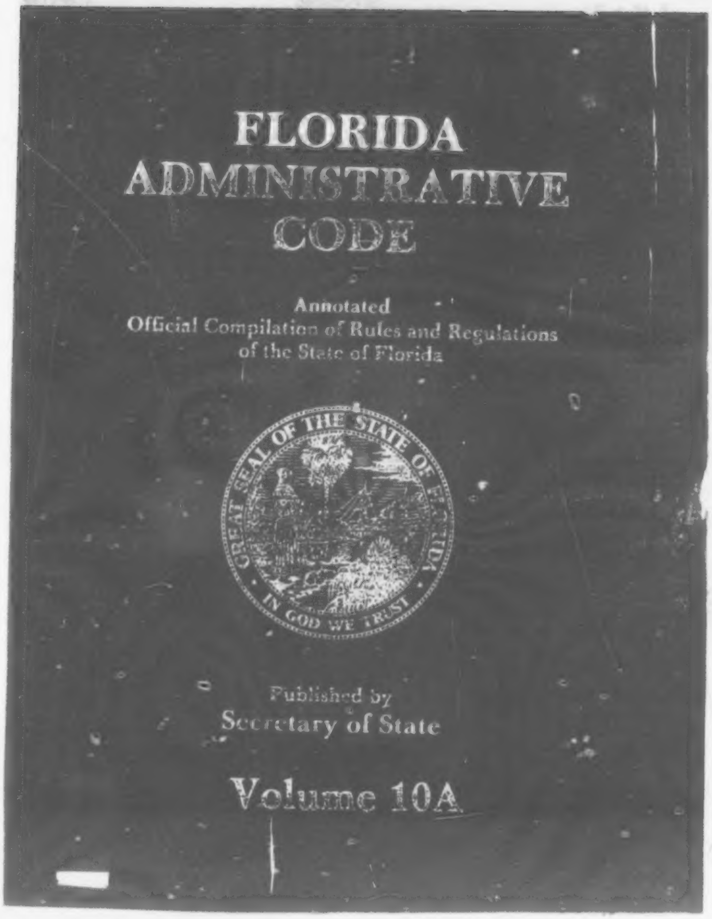
A physician may not represent to the public that the physician is specializing in any practice of medicine or limiting the physician's practice of medicine to any specialty unless the physician is identified by the Board as a specialist in that specialty.

.12 Penalties for Violation.

Violation of these regulations may result in referral by the Board to the Commission on Medical Discipline and may result in disciplinary action being taken by the Commission on Medical Discipline as set forth in Health Occupations Article, §§14-205 and 14-504, Annotated Code of Maryland.

Administrative History

Effective date: June 1, 1987 (14:11 Md. R. 1260)



FLORIDA
ADMINISTRATIVE
CODE

Annotated
Official Compilation of Rules and Regulations
of the State of Florida

Published by
Secretary of State

Volume 10A

CHAPTER 21M-24
ADVERTISING

21M-24.001 Advertising

21M-24.001 Advertising.

(1) The Board permits the dissemination to the public of legitimate information, in accordance with the Board's rules, regarding the practice of medicine and where and from whom medical services may be obtained, so long as such information is in no way false, deceptive, or misleading.

(2) No physician shall disseminate or cause the dissemination of any advertisement or advertising which is in any way false, deceptive, or misleading. Any advertisement or advertising shall be deemed by the Board to be false, deceptive, or misleading if it:

(a) Contains a misrepresentation of facts; or

(b) Makes only a partial disclosure of relevant facts; or

(c) Creates false or unjustified expectations of beneficial assistance; or

(d) Contains any representation or claims, as to which the physician, referred to in the advertising, does not expect to perform; or

(e) Contains any other representation, statement, or claim which misleads or deceives; or

(f) States or implies that the physician has received formal recognition as a specialist in any aspect of the practice of medicine unless he has in fact received such recognition and such recognizing agency is approved by the Board. For purposes of this rule, the Board approves the specialty boards of the American Board of Medical Specialties as a recognizing agency, and such other recognizing agencies as may receive future approval by the Board. However, a physician may indicate the services offered and may state that practice is limited to one or more types of services when this is in fact the case; or

(g) Represents that professional services can or will be competently performed for a stated fee when this is not the case, or makes representations with respect to fees for professional services that do not disclose all variables affecting the fees that will in fact be charged; or

(h) Conveys the impression that the physician disseminating the advertising or referred to therein possesses qualifications, skills, or other attributes, which are superior to other physicians, other than a simple listing of earned professional post-doctoral or other professional achievements recognized by the Board; or

(i) Fails to conspicuously identify the physician by name in the advertisement.

(3) As used in the rules of this Board, the terms "advertisement" and "advertising" shall mean any statements, oral or written, disseminated to or before the public or any portion thereof, with the intent of furthering the purpose, either directly or indirectly, of selling professional services, or offering to perform professional services, or inducing members of the public to enter into any obligation relating to such professional services.

(4) It shall be the responsibility of any duly licensed physician who utilizes the electronic media for the purpose of advertising to insure that an exact copy of the audio tape and/or video tape is maintained and preserved for a period of at least 90 days from the date that the actual advertisement is aired or shown through the electronic media.

Specific Authority 458.309 FS. Law Implemented 458.331(1)(d), (l), (n), (o) FS. History—New 3-31-80, Formerly 21M-24.01, Amended 11-15-88.

ABMS APPROVED SPECIALTIES AND SUBSPECIALTIES
(Effective March, [illegible])

Specialty Certificates	Subspecialty Certificates
Allergy & Immunology	Diagnostic Laboratory Immunology
Anesthesiology	Critical Care Medicine
Colon & Rectal Surgery	
Dermatology	Dermatopathology
	Dermatological Immunology/Diagnostic Laboratory Immunology
Emergency Medicine	
Family Practice	Geriatric Medicine
Internal Medicine	Cardiac Electrophysiology
	Cardiovascular Disease
	Critical Care Medicine
	Diagnostic Laboratory Immunology
	Endocrinology & Metabolism
	Gastroenterology
	Geriatric Medicine
	Hematology
	Infectious Disease
	Medical Oncology
	Nephrology
	Pulmonary Disease
	Rheumatology
Neurological Surgery	Critical Care Medicine
Nuclear Medicine	Nuclear Radiology (with ABRadiology)
	Radioisotopic Pathology (with ABPathology)
Obstetrics & Gynecology	Critical Care Medicine
	Gynecologic Oncology
	Maternal & Fetal Medicine
	Reproductive Endocrinology
Ophthalmology	
Orthopaedic Surgery	Hand Surgery
Otolaryngology	
Anatomic & Clinical Pathology	Blood Banking/Transfusion Medicine
Anatomic Pathology	Chemical Pathology
Clinical Pathology	Cytopathology
	Dermatopathology
	Forensic Pathology
	Hematology
	Immunopathology
	Medical Microbiology
	Neuropathology
	Radioisotopic Pathology
Pediatrics	Diagnostic Laboratory Immunology
	Pediatric Cardiology
	Pediatric Critical Care Medicine
	Pediatric Endocrinology
	Pediatric Gastroenterology
	Pediatric Hematology-Oncology
	Pediatric Nephrology
	Pediatric Pulmonology
	Neonatal-Perinatal Medicine
Physical Medicine and Rehabilitation	
Plastic Surgery	Hand Surgery
Aerospace Medicine	
Occupational Medicine	
Public Health & General Preventive Medicine	
Psychiatry	Child Psychiatry
Neurology	
Neurology with Special Qualifications in Child Neurology	
Radiology	Nuclear Radiology
Diagnostic Radiology	
Radiation Oncology	
Radiological Physics	
Surgery	Hand Surgery
	Pediatric Surgery
	Surgical Critical Care
	General Vascular Surgery
Thoracic Surgery	
Urology	

TEXAS STATE BOARD OF MEDICAL EXAMINERS
October 1988

Advertising
.164.1

The following Rules are proposed under the authority of Article 4495b, VACS:

164.1 Misleading or Deceptive Advertising.

(a) For the purpose of this Rule and for the purpose of definition of the term "advertising" as set forth in Section 3.08 (6) and (7), Article 4495b, VACS, the said term shall be deemed to include any public notice or promotional material published in the press or broadcast or televised over the air; the descriptive language used on professional cards or circulars, on professional or personal letterheads, on billing statements, in telephone listings, on signs, or in any other public notification, announcement, or designation by the physician of his or her medical practice or limitation thereof.

(b) A physician's authorization of or use in any advertising for his or her practice of the term "board certified" or any similar words or phrase calculated to convey the same meaning shall constitute misleading or deceptive advertising under Section 3.08 (6) unless the advertising contains the following information:

(1) the complete name of the specialty board which conferred the board certification;

(2) a statement that the Board conferring the certification is not recognized by the American Board of Medical Specialties or by the Advisory Board for Osteopathic Specialists and Board Certification of the American Osteopathic Association if such Board is not so recognized;

(3) the board certification cited in the advertising has not expired and is currently in force and effect or was at the time the advertising in question was published, broadcast or prepared.

(c) An advertisement describing the physician as a specialist by use of a noun denoting medical specialty such as "dermatologist," "plastic surgeon," "otolaryngologist," "orthopedic surgeon," "internist," or similar designation by such "specialty noun" shall be followed by the words "self designated" unless the physician so advertising shall have successfully completed training recognized as a prerequisite for Board certification in that medical specialty or subspecialty by either the American Board of Medical Specialists or the Advisory Board for Osteopathic Specialists and Board Certification of the American Osteopathic Association.

SUMMARY STATEMENT ON DELINEATION OF PRIVILEGE

As clearly stated by the CMSS Ad Hoc Committee on Designation of a Specialist (see I-A), self-designation alone is not acceptable as a criterion for identifying a specialist.

It is the ASPRS position that a physician applying for an appointment in an academic or clinical department or division of plastic surgery as a Plastic Surgeon shall have completed training acceptable for certification by the American Board of Plastic Surgery or its Canadian equivalent as a basic requirement.

ASPRS has no quarrel with the granting of privileges to perform a plastic surgery procedure if an applicant has documented training and expertise and meets the criteria of a specialist as defined by the CMSS criteria relevant to the specific area of delineation.

It must be emphasized that "plastic surgery" and "plastic surgeon" are not interchangeable terms. The lay public and persons charged with the evaluation of an applicant's delineation of privileges must not be deceived. The marketplace will always find room for the well-qualified and talented physician, The individual seeking plastic surgery has an absolute right to voluntary disclosure of a physician's full credentials and should not be misled by a physician's pointing to the privilege granted by an unwary institution that accepts less than the highest standards to credential its staff.

The Royal College of Physicians and Surgeons of Canada has addressed the problem of self-designated interests versus recognized training and certification by issuing the following statement on the *Use of Specialty Designations and Indication of Practice*

> *Regulation 448, Section 23(1) under the Health Disciplines Act states "a member to whom a certificate in a specialty has been issued by the Royal College of Physicians and Surgeons of Canada may use a designation for the specialty approved by the Royal College of Physicians and Surgeons of Canada."*
>
> *The Royal College of Physicians and Surgeons of Canada has issued the following policy statement on the use of names of specialty qualifications.*
>
> > *Although there is overlap among the various specialties, physicians and the public have an understanding of the work done by specialists that is based, by long tradition, on the names that the College uses to designate the specialty qualifications offered by the College (Royal College.*

> > *These names should be used when referring to specialty qualifications on the above mentioned documents. If, in addition to naming his/her College specialty, a Certificant or Fellow wishes to describe his/her field of practice, the medical term used should not include names of other College specialties.*
>
> *Members are reminded that Section 27 of Regulation 448 defines professional misconduct to include:*
>
> > *"announcing or holding out to the public that the member is a specialist or is specially qualified in a branch of medicine where the member is not qualified as a specialist."*

The College of Physicians and Surgeons of Ontario is one of ten provinces that has issued a ruling based on this statement. Their ruling is the following:

> *A member may indicate the field of practice to which the practice is limited but this must not be stated as if it were a specialty. For example, a member who does not hold a specialty certificate in ophthalmology may not state his practice is "ophthalmology" but could state his practice is "limited to diseases of the eyes." If on the other hand the member holds a specialty certificate from the Royal College of Physicians and Surgeons of Canada, he must not imply that he is a specialist in a field other than the one in which he holds a specialty certificate.*
>
> *It is appropriate for a specialist to indicate the specialty in which he holds a certificate from the Royal College and then to indicate that his or her practice is restricted to a specific field.*

The American Society of Plastic and Reconstructive Surgeons salutes the positive example of the Royal College of Physicians and Surgeons of Canada. Their effort has resulted in a clear statement of Health Law that protects the public by identifying the value of approved training and certification in the selection of a specialist. The American people do not deserve less. In the interim, until our Health Law speaks to this issue, ASPRS will continue to urge this high standard in the granting of privileges as a plastic surgeon.

FROM: LEGISLATIVE COMMITTEE
SUBJECT: ANNUAL REPORT
DATE: April 10, 1989

510 - 6 (88/89)
Page 1

This is from the
California Society of
Anesthesiology

FOR INFORMATION ONLY:

The Legislative Days held April 4-5, 1989 in Sacramento were a success with well over 50 physicians and a smaller, but willing, contingent of legislators on hand. Attendees were provided background information on the following three subjects:

1. *Access to Care:* The several measures which propose to extend the availability of health care coverage to Californians who are presently uninsured.
2. *Defense of MICRA.* (Medical Injury Compensation Reform Act)
3. *Dental Anesthesia Legislation.*

They also were provided with copies of the ASA publication *"Anesthesia and You"* as well as a position paper from the ASA's Committee on Anesthesia Care Team entitled *"Differences in Capabilities and Services Provided by Anesthesiologists and Nurse Anesthetists"*. Included in the packet was *"How to Play the Game -- Your Guide to Influencing Legislation"*

The breakfast and luncheon the day following our social gathering was also well attended, with many visits to the legislature. Although these contacts are not critical this year, we continue to lay down a foundation of familiarity and trust on which we can build for the future.

After conclusion of the luncheon, there was an informal legislative committee meeting to discuss and critique this year's legislative experience as well as make preliminary plans for next year's event. As a result of that meeting a list of attendees, "No Shows", and GASPAC members is being compiled. Letters will be sent to all in appreciation, encouragement, and to solicit membership as the case may be.

Dr. Jackson has requested a report on my activities at the CMA Commission on Legislation, and I am happy to comply. The last meeting I attended was held March 22nd. The issues discussed were far-ranging and a summary was circulated entitled *"CSA Legislative Status Report"*, April 4, 1989. Rather than reiterating the bills which were discussed or the positions recommended by the CMA Commission on Legislation, it is my purpose to help the board understand my impressions of the process and priorities of the CMA Commission on Legislation.

First you must understand that the position recommended by the CMA Commission on Legislation is *NOT* a distillation of thoughtful input by caring physicians representing medicine in California. Rather it *IS* a collection of special interest groups pleading their cases in the largest turf battle in which I have been involved. Although quality of care issues are often mentioned, issues are not decided on their relative merits with respect to global insight into quality medical care.

For example, SB 1163 (Stirling) deems as unprofessional, conduct subject to licensure sanctions, certain advertising as to specialty certification or training including claims of certification of bogus boards. Clearly this legislation, if adopted, would benefit its sponsors -- the California Society of Plastic Surgeons -- but it would also, in my analysis, serve to improve patient care. The bill's major thrust is to require physicians who advertise and operate as "cosmetic, facial or reconstructive plastic surgeons" to be truthful in listing their qualifications and training. This sounds very similar to a "Truth in Anesthesia" bill which threatened the same groups of physicians -- namely the ENT surgeons, dermatologists and

(OVER)

ophthalmologists. These are all physicians who perform plastic surgery and find it equally offensive to identify their true board certification status. These arguments from the floor at the CMA Commission on Legislation were less than convincing. The ENT representative thought that it would prove a financial burden to his particular specialty to have to change their billing forms, business cards, etc., to comply with the bill's requirements. The dermatologists found it unacceptable to have to reveal that they are not plastic surgeons to the patients who come to them for liposuction. The ophthalmology representative insisted that it was not in the best interests of his constituency to list ophthalmology as the only board certified status for patients on which they performed eye lid or face lift surgery.

It was my opinion that the proper consideration from the patient's point of view was full disclosure of training and qualifications. However, the members of the CMA Commission on Legislation overwhelmingly voted to oppose this bill and two other bills by the plastic surgeons. Their position was a result of the above testimony added to the concerns that the lobbyist hired by the plastic surgeons was a moustache-twisting, no-good-nick (actually he formerly worked for the CMA) who couldn't be trusted.

It is clear to me that although the members of the CMA Commission on Legislation can cite "reasons" not to support this proposed legislation, these "reasons" are a smoke-screen which hides the true nature of their objections. They just don't want the public to be aware of their qualifications and training. They are threatened by having to give up their bogus board status just as they were threatened by the thought of having to inform patients of the training and qualifications of the practitioner providing anesthesia care.

Now it should be clear to you that our efforts, independent of CMA, to influence legislation is essential. We cannot depend on physicians who do not understand our motives to adequately represent our best interests. Other specialties share our frustration and may one day prove important allies. It is only through a strong independent lobby effort coupled with continued participation on the CMA level that we can best represent our members in Sacramento.

Respectfully submitted,

Patrick G. Burch, M.D.
Chairman

AMERICAN BOARD OF MEDICAL SPECIALTIES
One American Plaza, Suite 805 Evanston, Illinois 60201 312/491-9091

September 17, 1984

Donald T. Moynihan, M.D.
570 Beachland Blvd.
Vero Beach, FL 32960

Dear Dr. Moynihan:

In response to your September 6th letter, I write to confirm that the American Board of Plastic Surgery is the only member board of the American Board of Medical Specialties which has the label "Plastic Surgery". The criteria used by the ABMS is recognition by the Liaison Committee on Specialty Boards, an organization sponsored by the ABMS and the AMA. In addition to approval by the LCSB, a new board must be approved by ABMS to become a member. The issue of whether or not there is a residency program is no the single criterion, though the presence of recognized programs of residency training are par the process. The Accreditation Council on Graduate Medical Education (ACGME) only accredits specialties which have been approved by the ABMS.

A recognized subspecialty is one which is approved by ABMS and which is sponsored by one of the 23 member boards of ABMS. There is some confusion about terminolog because the "specialty codes" used by the AMA for thei self-designated record of professional activities is used only for their Physician Masterfile and thei Directory, but does not imply that the AMA recognize the same fields as specialty boards or as subspecial Recently the AMA Board of Trustees developed a plan to change the list of designated specialty codes to mak it similar to or the same as the ABMS list, but you have to check with them on this issue.

However I can state that the inclusion of "Surgery, Fac Plastic" does not establish Facial Plastic Surgery an AMA recognized subspecialty. It only means tha presently accepted for self-designation of special their Masterfile and Directory.

Sincerely yours,

Donald G. Langsley, M.D.
Executive Vice Presiden

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AMERICAN BOARD OF MEDICAL SPECIALTIES
One Rotary Center, Suite 805 Evanston, Illinois 60201-4889 312/491-9091

RECEIVED
JAN 30 1989
REP. RON WYDEN

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American Board of Colon & Rectal Surgery
American Board of Dermatology
American Board of Emergency Medicine
American Board of Family Practice
American Board of Internal Medicine
American Board of Neurological Surgery
American Board of Nuclear Medicine
American Board of Obstetrics & Gynecology
American Board of Ophthalmology
American Board of Orthopaedic Surgery
American Board of Otolaryngology
American Board of Pathology
American Board of Pediatrics
American Board of Physical Medicine
and Rehabilitation
American Board of Plastic Surgery
American Board of Preventive Medicine
American Board of Psychiatry & Neurology
American Board of Radiology
American Board of Surgery
American Board of Thoracic Surgery
American Board of Urology

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Federation of State Medical Boards of U.S.
National Board of Medical Examiners

Public Members
Robert J. Blendon, Sc.D.
Renee C. Fox, Ph.D.

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President
[illegible] E. [illegible], M.D.
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Coordinator of Publications

January 23, 1989

The Honorable Ron Wyden
Chairman
Subcommittee on Regulation & Business Opportunities
House Small Business Committee
B363 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Wyden:

I understand that your Subcommittee has been interested in the problem which the public has in identifying the meaning of a statement or advertisement by a physician to the effect that he or she is "board certified".

To most citizens, being board certified means that a physician has achieved a high level of specialist competence by virtue of training and successful completion of a rigorous examination. However, that assurance does not always obtain. The unfortunate fact is that any individual or group can organize a "board", can issue certificates under any requirements it establishes and these requirements may vary from no training or substituting experience for an examination to the very rigorous requirements of the 23 Boards which are members of the ABMS (listed on this letterhead) and which are so recognized by the American Medical Association and the American Board of Medical Specialties. It was for this very reason that the ABMS was established in 1933. It has a process for recognizing and approving new boards through the Liaison Committee on Specialty Boards (LCSB), a creature of the American Medical Association and the American Board of Medical Specialties. That process is described in the enclosed Essentials for the Approval of Examining Boards in Medical Specialties. Only the 23 Boards listed on this letterhead have met those requirements to date.

On the other hand we are aware of at least 102 self-designated boards and enclose a list of these which we understand do exist. We have no information about their standards or their requirements. We only know that some of them advertise their existence to physicians inviting them to obtain the certification of that board. We also know that many physicians who obtain such certification advertise it to the public.

The Honorable Ron Wyden
January 23, 1989
Page two

The citizen who is confused by these allegations of being board certified is at a disadvantage. The citizen has no way of understanding the complicated process of approval of boards either by the ABMS/AMA or by the American Osteopathic Association in the case of Osteopathic Boards. The term "board certified" is meaningful only if the public can be assured that the board has met high standards and has a process to offer assurance of accredited training and successful completion of a rigorous evaluation. That is the very reason for the ABMS and the LCSB. We have tried to increase public awareness of this situation but you will understand what a complex issue this has become and what a challenge it is to educate all of the citizens of this country about it.

I would hope that your Subcommittee would consider some type of legislation which states that one who represents himself to be a certified medical specialist is one who is certified by a Member Board of the American Board of Medical Specialties or the American Osteopathic Association. This could be approached in a variety of ways either through legislation on false and deceptive advertising or on legislation concerning payment for medical services from federal funds. I understand that at least two states have investigated this issue but it is so complicated that legislation at the federal level might be advantageous if it is within the purview of federal authority.

The American Board of Medical Specialties would be delighted to offer further information or to present testimony on this issue. Please do not hesitate to contact us.

Cordially,

Donald G. Langsley, M.D.
Executive Vice President

DGL/bh/10

Enclosures (2)

cc: ABMS Executive Committee

APPROVAL OF EXAMINING BOARDS IN MEDICAL SPECIALTIES

Since 1934, medical specialty boards have been officially approved by action of the American Board of Medical Specialties (ABMS) and the American Medical Association Council on Medical Education (AMA/CME). This determination begins with review by the Liaison Committee for Specialty Boards (LCSB), an organization sponsored by the AMA/CME and the ABMS.

The LCSB consists of four voting representatives from the ABMS Executive Committee and four voting representatives from the AMA/CME. The Chairman of the AMA/CME serves as Chairman of the LCSB. The Executive Vice President of the ABMS serves as Secretary of the LCSB (without vote). The Secretary of the AMA/CME also serves on the LCSB (without vote). The LCSB meets on the call of the Chairman at no fixed intervals, but generally meets annually.

The functions of the LCSB are:

1) to receive applications for approval as a medical specialty certifying board.
2) to evaluate applications according to the current version of the "Essentials for Approval of Examining Boards in Medical Specialties."
3) to hold hearings on such applications if appropriate to do so.
4) to have the Secretary foward approved applications to the sponsors of the LCSB (the ABMS and the AMA) along with the recommendations of the LCSB. Both the AMA/CME and the ABMS must act affirmatively by a ⅔ majority if a new board is to be approved. LCSB is not required to ratify the actions of its sponsors.
5) to notify the applicant of the action of the sponsors of LCSB. If the application is disapproved, the applicant may reapply after 12 months.

Action on applications for approval of examining boards in medical specialties is based on the *Essentials for Approval of Examining Boards in Medical Specialties*, a collaborative effort of the ABMS and the AMA/CME begun in 1934. The original *Essentials for Approval of Examining Boards in Medical Specialties* was based on recommendations of the ABMS Committee on Standards and Examinations and was approved by the AMA House of Delegates in June, 1934. The *Essentials* have undergone several revisions, both major and minor, since 1934. The present, tenth revision of the *Essentials* is a joint document approved by both organizations. It embodies the policies of both the ABMS and the AMA pertaining to specialty boards while retaining each organization's privilege of independent consideration and action. The *Essentials* describe the standards and procedures by which applications for approval of new examining boards are evaluated.

The approved specialty boards and the current list of categories of certification in each of those specialties are listed on the inside front cover of this edition of the ABMS *Annual Report and Reference Handbook*.

TENTH REVISION OF
ESSENTIALS FOR APPROVAL OF EXAMINING BOARDS IN MEDICAL SPECIALTIES

Approved by ABMS September, 1986 and by AMA December, 1986

Section I. **Function of the Liaison Committee for Specialty Boards (LCSB).**

The American Board of Medical Specialties (ABMS), by authority of its member boards and other member organizations, and the American Medical Association Council on Medical Education (AMA/CME), by authority delegated by the AMA House of Delegates, have established the LCSB consisting of four representatives selected from each body. The Chairman of the AMA/CME shall be the Chairman of the LCSB. The Executive Vice President of the ABMS shall be the Secretary of the LCSB but shall not vote. The Secretary of the AMA/CME shall attend meetings of the LCSB but shall not vote.

The purpose of the Liaison Committee is:

A. To receive applications for approval of medical specialty boards and make recommendations to its parent bodies.

B. To provide a mechanism for contact with petitioning groups through the Secretary of the LCSB on matters related to approval of new specialty boards and for transmission of decisions of the ABMS and AMA/CME to applicants.

C. To determine as expeditiously as possible if the applicant board has complied with the Essentials for approval.

To assist in attaining these objectives, the LCSB is authorized to appoint consultants known to the ABMS and the AMA/CME to be qualified and knowledgeable in the special field which the new specialty board intends to represent.

Section II. **Definition of a Specialty Board.**

A specialty board is a separately incorporated, financially independent body which determines its requirements and policies for certification, selects the members of its governing body in accordance with the procedures stipulated in its bylaws, accepts its candidates for certification from persons who fulfill its stated requirements, administers examinations, and issues certificates to those who submit to and pass its evaluations.

Section III. **Objectives and Functions of Specialty Boards.**

A fundamental objective of all approved boards is to act in the public interest by contributing to the improvement of medical care by establishing the qualifications for candidates and by evaluating individuals who apply for certification.

The primary function of all approved specialty boards is to evaluate the qualifications of candidates who apply and to certify as Diplomates those who are found to be qualified.

To accomplish this function, specialty boards shall:

A. Determine whether or not candidates have received adequate preparation in accord with educational standards established by the specialty board.

B. Conduct comprehensive evaluations of the knowledge and experience of such candidates, and

C. Issue certificates to those physicians found qualified under the stated requirements of the board.

A related function of approved specialty boards is to assist in maintaining and elevating the standards of graduate medical education and facilities for specialty training in collaboration with other concerned organizations and agencies.

Section IV. **Criteria for Approval of New Examining Boards.**

A. The establishment of a new specialty board signifies the differentiation of a new specialty which must be based on major new concepts in medical science.

B. A new medical specialty board must represent a distinct and well defined field of medical practice. It may entail special concern with the problems of patients according to age, sex, or organ systems or with the interaction between patients and their environment.

A new certifying board must be based on substantial advancement in medical science. The needed training must be sufficently complex or extended that it is not feasible to include it in established training programs.

D. A board must require evidence that its diplomates have acquired capability in a stated area of medicine and will demonstrate special knowledge in that field.

E. A plan must be presented whereby preparatory programs in graduate medical education will be developed for accreditation by the Accreditation Council for Graduate Medical Education (ACGME). New boards may be permitted under conditions stated by the petitioning board and approved by the LCSB, to approve training or experience or a combination of both as equivalent to that acquired in accredited training programs until accreditation by the ACGME is in place.

The applicant must present satisfactory evidence that the proposed board has broad professional support in the specialty, and that approval will promote and enhance recognition of a single standard of preparation for practice in each specialty.

In order to promote public and professional understanding and recognition of a single standard in each specialty and to promote efficiency of the evaluation process, only one certifying board will be recognized in each specialty.

G. While it is recognized that considerable variation among certifying boards may be permitted, the operational plan must include satisfactory details in the following areas:

(1) Names, professional affiliations and professional accomplishments of the sponsors.

(2) Structure—the composition of the board should provide for representation of appropriate organizations ~~and for effective operation of the~~ board.

(3) Content of the field—data from a detailed analysis of the professional area, including present and future public needs and professional interests should be presented. Such analysis ~~should be used for development and continued~~ evaluation of standards for certification.

(4) While requirements may not be fully developed at the date of application, a plan for development and validation of the requirements should be presented.

(5) A detailed plan for evaluating individual candidates should be presented.

(6) The financial support for a valid, objective program of candidate evaluation, as well as other necessary activities in graduate education must be included in the plan. The data presented should include projected numbers of potential diplomates and projected ~~certification fees~~.

Section V. **Procedure for Approval of New Specialty Boards.**

A. The application should be directed to the Secretary of the LCSB who also serves as Executive Vice President of the ABMS.

B. The LCSB may conduct a hearing before making a recommendation on any application.

C. The application should adhere to the following outline:

(1) The name of the proposed specialty board asking for approval.

(2) The proposed objectives and function of the petitioning board.

(3) The names of the sponsoring organizations.

(4) A detailed statement describing how compliance with each of the criteria in Section IV is achieved.

(5) A description of the proposed organization, the names and professional qualifications of the proposed officials, the names and addresses of the founding members, their qualifications, and the organization which each member represents.

(6) A copy of the proposed or existing Constitution and Bylaws.

(7) A copy of the proposed or existing Articles of Incorporation.

(8) An outline of the qualifications to be required of applicants for certification

(9) The number and names of institutions providing residency or other acceptable training programs in the specialty, the total number of residencies available, and the number of residency training programs that can be developed.

(10) The approximate number of physicians engaged in the practice of the specialty.

(11) A copy of the proposed application form for candidates for certification.

(12) Provisions, if any, for certifying physicians practicing in the specialty without examination or accredited training. The statement should include the qualifications and the number of physicians to be certified in that manner.

D. The responsibility of the LCSB is not limited to initial evaluation of the certifying boards in medical specialties. Proposed changes in policy which differ substantially from those policies and procedures which prevailed at the time of approval should be reported to the Secretary of the LCSB for transmittal to the LCSB for action as required.

E. The LCSB shall submit a report and recommendations to the ABMS and the AMA/CME for consideration by their members within one year after receipt of the application.

F. The ABMS and the AMA/CME shall independently act on the application after receiving a recommendation for approval from the LCSB. An affirmative vote of two-thirds of the members of each of the ABMS and the AMA/CME, present and voting provided a quorum is present, is required to approve the new board. Each parent of the LCSB shall report its action to the Secretary of the LCSB. If one of the parents disapproves, it must transmit the reasons for disapproval to the LCSB.

G. If possible, within twelve months of receipt of the application as defined in Section V.C., the LCSB shall inform the petitioning group of their decision. If the decision is negative the petitioner may request reconsideration by the LCSB which could include an opportunity for the petitioner to be heard in person. Following reconsideration by the LCSB, the provisions of Section V.F. will apply. The LCSB will then transmit the final action of the parents of the LCSB, after reconsideration, to the petitioner.

H. The petitioner may file a formal appeal in the event of a negative decision in the reconsideration process. This will be initiated by a request for an appeal to the Secretary of the LCSB who will transmit that information to the ABMS and the AMA/CME. The appeal will be heard by a five-person panel consisting of two members of the ABMS Executive Committee who are not members of the LCSB (appointed by the ABMS Executive Committee) and two members of the AMA/CME who are not members of the LCSB (appointed by the AMA/CME). These four individuals will choose a "public member" who may not be a member of the ABMS or the AMA/CME. The appeals panel will hear the appeal of the petitioner and would then transmit its recommendations to the LCSB. After considering the recommendations of the appeals panel, the LCSB will take final action on the appeal and will notify both the petitioners and the parents of the LCSB.

I. Following approval by the LCSB, ABMS, and AMA/CME, the board shall not issue new certificates to individuals who received certification prior to approval without requiring that each meet the same requirements as candidates applying for board certification after approval.

Section VI. **Meetings of the LCSB**

The LCSB shall meet at least annually at the call of the Chairman. On petition of five members of the LCSB, the Chairman shall call a special meeting. The Chairman may also call a special meeting to conduct any business which comes to the attention of the Secretary of the LCSB.

Section VII. **Amendments or Revisions of the Essentials for Approval of Examining Boards in Medical Specialties.**

Amendments or revisions of the Essentials must be approved by the ABMS and the AMA House of Delegates. Those amendments or revisions which have been approved by two-thirds of the LCSB shall be transmitted by the Secretary to these parent groups for consideration and vote. Changes in the Essentials shall take effect on approval of both the ABMS and the AMA House of Delegates.

AMERICAN BOARD OF MEDICAL SPECIALTIES
One Rotary Center, Suite 805 Evanston, Illinois 60201-4889 312/491-9091

Members
American Board of Allergy & Immunology
American Board of Anesthesiology
American Board of Colon & Rectal Surgery
American Board of Dermatology
American Board of Emergency Medicine
American Board of Family Practice
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American Board of Neurological Surgery
American Board of Nuclear Medicine
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American Board of Ophthalmology
American Board of Orthopaedic Surgery
American Board of Otolaryngology
American Board of Pathology
American Board of Pediatrics
American Board of Physical Medicine
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Director of Research
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Director of Operations
Margaret F. Kruty
Coordinator of Publications

October 31, 1988

SELF-DESIGNATED BOARDS

Information exists in the ABMS files on the following self-designated boards. They are called "American Board of ________________" unless otherwise designated, and each purports to certify physicians.

Abdominal Surgeons
Acupuncture Medicine
Addictionology
Aesthetic Plastic Surgery
Alcoholism & Other Drug Dependencies (AMSAODD)
Algology (Chronic Pain)
Ambulatory Anesthesia
Anthroscopy
Bariatric Medicine
Bionic Psychology
Bloodless Medicine & Surgery
Chelation Therapy
Chemical Dependence
Clinical Chemistry
Clinical Ecology
Clinical Neurology
Clinical Neurophysiology
Clinical Neurosurgery
Clinical Nutrition
Clinical Orthopaedic Surgery
Clinical Pharmacology
Clinical Polysomnography
Clinical Psychiatry
Clinical Psychology
Clinical Toxicology
Cosmetic Plastic Surgery
Cosmetic Surgery
Council of Non-Board Certified Physicians
Critical Care in Medicine & Surgery
Disability Evaluating Physicians
Electrodiagnostic Medicine
Electroencephalography
Electromyography and Electrodiagnosis
Environmental Medicine
Epidemiology (College)
Facial Cosmetic Surgery
Facial Plastic Surgery
Forensic Psychiatry
Forensic Toxicology

Hand Surgery
Head, Facial & Neck Pain & TMJ Orthopedics
Health Physics
Homeotherapeutics
Hypnotic Anesthesiology, National Board for
Industrial Medicine & Surgery
Insurance Medicine
Int'l. Cosmetic & Plastic Facial Reconstr. Stds.
Interventional Radiology
Laser Surgery
Law in Medicine
Malpractice Physicians
Maxillofacial Surgeons
Medical Accreditation (American Federation for)
Medical Genetics
Medical Hypnosis
Medical Laboratory Immunology
Medical-Legal Analysis of Medicine & Surgery
Medical Legal & Workers Compensation Medicine & Surgery
Medical Legal Consultants
Medical Microbiology
Medical Preventics (Academy)
Medical Toxicology
Medical Psychotherapists
Microbiology (Medical Microbiology)
Military Medicine
Neurologic & Orthopaedic Dental Medicine & Surgery
Neurological & Orthopaedic Medicine
Neurological & Orthopaedic Surgery
Neurological Microsurgery
Neuro-Orthop. Dental Medicine & Surgery
Neuro-Orthop Electrodiagnosis
Neuro-Orthop. Laser Surgery
Neuro-Orthop. Psychiatry
Neuro-Orthop. Thor. Medicine/Surgery
Nutrition
Orthopaedic Microneurosurgery
Otorhinolaryngology
Pain Management (American Academy of)
Pain Management Specialties
Pain Medicine
Percutaneous Diskectomy
Plastic Esthetic Surgeons
Prison Medicine
Psychiatric Medicine
Psychiatry (American National Board of)
Psychoanlaysis (American Examining Board in)
Psychological Medicine (International)

Quality Assurance and Utilization Review
Radiology and Medical Imaging
Rheumatologic Surgery
Rheumatological and Reconstructive Medicine
Ringside Medicine & Surgery
Skin Specialists
Spinal Cord Injury
Spinal Surgery
Sports Medicine/Surgery
Toxicology
Trauma Surgery
Traumatologic Medicine & Surgery
Tropical Medicine
Ultrasound Technology
Urologic Allied Health Professionals

Total - 102

STATEMENT OF CARL BATTAGLIA, M.D., PRESIDENT, AAAHC

Accreditation Association for Ambulatory Health Care, Inc.
9933 LAWLER AVENUE ● SKOKIE, ILLINOIS 60077-3702 ● (312) 676-9610

ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE

Testimony Before the
Committee on Business
Subcommittee on Regulation, Business
Opportunities, and Energy,
June 28, 1989

ACCREDITATION OF OUTPATIENT OFFICE-BASED COSMETIC SURGERY PRACTICES

The Accreditation Association for Ambulatory Health Care ("AAAHC") is pleased to present this testimony before the Subcommittee on Regulation, Business Opportunities and Energy of the House Committee on Small Business, concerning the accreditation of outpatient office-based cosmetic surgery practices. AAAHC is the primary accreditation association dedicated to the accreditation of a wide range of ambulatory care facilities, and we hope that our testimony will be useful to the Committee in assessing the need for legislation in this area.

I. THE ORGANIZATION, HISTORY, AND PURPOSE OF AAAHC

AAAHC was incorporated as an Illinois not-for-profit corporation in 1979, but its history spans nearly twenty years. As early as the mid-1960s, the American Group Practice Association ("AGPA") (then the American Association of Medical Clinics) began discussing the possibility of establishing a national accreditation program for medical group practices to assure the provision of high quality care. After considerable study and deliberation, AGPA formed its Commission on Accreditation and charged it with the development of an accreditation program under AGPA's auspices. The AGPA Commission conducted its first on-site visits in 1969 and, by the 1976 annual meeting, AGPA had conducted a total of 182 initial surveys and had scheduled 47 additional surveys, evidence of the growing interest in voluntary accreditation.

In the late 1960s and early 1970s, in response to the shift of health care services from the hospital to other health care settings, the Joint Commission on Accreditation of Hospitals (now the Joint Commission on Accreditation of Health Care Organizations ("JCAHO")) and the National Association of Neighborhood Health Centers (now the National Association of Community Health Centers) began to develop standards and survey procedures for ambulatory health care organizations. At about the same time, AGPA opened its accreditation program to non-members and began to explore the feasibility of forming an accreditation program for ambulatory health care within JCAHO. JCAHO, in response to AGPA interest, approved the formation of the Accreditation Council (the "Council") for Ambulatory Health Care, which was formally organized in May 1975. However, in October 1978, JCAHO decided to dissolve its accreditation councils; the Accreditation Council for Ambulatory Health Care was dissolved; and the members of the Council incorporated AAAHC on March 22, 1979.

AAAHC currently has ten members, which are national trade and professional associations that represent a wide variety of organized health care delivery systems. AAAHC's current members are:

American Academy of Dental Group Practice (AADGP)

American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS)

American College Health Association (ACHA)

American College of Occupational Medicine (ACOM)

American Group Practice Association (AGPA)

American Society of Outpatient Surgeons (ASOS)

Federated Ambulatory Surgery Association (FASA)

Medical Group Management Association (MGMA)

National Association of Community Health Centers, Inc. (NACHC)

Outpatient Ophthalmic Surgery Society (OOSS).

AAAHC accredits a wide range of ambulatory care facilities including, for example, ambulatory health care clinics; ambulatory surgery centers ("ASCs"); birthing centers; college and university health services; community health centers; dental group practices; faculty medical practice plans; health maintenance organizations ("HMOs") and other prepaid or managed care systems; hospital-sponsored ambulatory care clinics and surgery centers; multi-specialty group practices; networks and groups of health care organizations; occupational health services; office surgery centers and practices; single-specialty group practices; surgical recovery centers; and urgent or immediate care centers.

Because of the quality of the standards and thoroughness of its surveys, AAAHC has been recognized and accepted by all types of third party payors (Blue Cross and Blue Shield plans, commercial carriers, HMOs, governmental agencies) as meeting their conditions for participation in reimbursement programs. In recognition of the requirements of risk management and the quality assurance program in AAAHC's standards, a number of professional liability carriers extend a discount in premium coverage to ASCs and single and multi-specialty group practices accredited by AAAHC. CHAMPUS has cited AAAHC as an appropriate accreditation agency. In short, since its founding, AAAHC's accreditation program has gained acceptance and recognition from the health care community, government, and the general public. It has now established itself as a leader in the maintenance and development of high quality, cost effective health care in the United States.

II. TRENDS IN OUTPATIENT SURGERY

Over the past ten years, outpatient surgery has grown more quickly than virtually any other sector of the health care marketplace. This trend towards the performance of surgical procedures on an outpatient basis is caused by a number of factors.

- Advances in technology have facilitated the performance of an increasing number of surgical procedures on an outpatient basis. It is now estimated that due to advances in technology, anesthesia, and surgical techniques, over 50 percent of all surgical procedures can be safely and cost-effectively performed on an outpatient basis.

- Patients are increasingly demanding the convenience and cost savings of outpatient surgery.

- Physicians often view outpatient surgery as a means to provide surgical procedures more efficiently; moreover, outpatient surgery affords the surgeon the opportunity to exercise greater control over the surgical environment while minimizing the costs to patients.

- Medicare's ASC program has provided facility reimbursement to cover the overhead costs of Medicare-certified facilities at a considerable savings to the Federal Government when contrasted to inpatient surgery.
- A number of private payors have followed Medicare's lead and have provided incentives for surgical procedures to be performed on an outpatient basis by authorizing payment of ASC facility fees and other physician incentives for outpatient surgery.
- State regulatory barriers for the establishment of ASCs (including, for example, onerous certificate of need requirements) have been eliminated in most states, and most states do not impose certificate of need or other regulatory barriers to the performance of office-based surgery.

A recent survey conducted by the SMG Marketing Group indicates that the number of ASCs totalled 964 centers at year end 1988; Medicare statistics confirm that today, there are almost 1,000 Medicare-certified ASCs. SMG data suggests that approximately 9.2 percent of the procedures performed in ASCs in 1988 involved plastic surgery.

Unfortunately, it is much more difficult to measure the growth in office-based surgical facilities which are not Medicare-certified or state licensed. The first SMG Marketing Group study of office-based surgery has not yet been published; however, preliminary results indicate that over the next two years, physician office-based surgery is expected to grow at a significant rate and that in 1990 physicians will perform more than 1.25 million surgical procedures in their offices, up from about 842,000 procedures in 1988. Currently, about 7 percent of the nation's 12 million outpatient procedures take place in physicians' offices.

It should be noted that it is often difficult to distinguish between ASCs and office-based surgery. In fact, it is estimated that a number of Medicare-certified ASCs are actually single-specialty surgical suites operated in conjunction with physicians' offices. For example, a facility which would be considered an office-based surgical suite in one state might be considered an ASC in another: The definition of what constitutes an "ambulatory surgical center" as opposed to an office-based surgical practice varies significantly depending on state law. This state-by-state variation complicates efforts to obtain accurate statistics concerning the extent of office-based surgery, and may complicate efforts at federal regulation.

Moreover, there is considerable confusion concerning what constitutes cosmetic surgery. For example, some cosmetic surgery procedures can also be categorized as ophthalmic or dermatological procedures.

AAAHC believes that in light of these ambiguities, any efforts at federal regulation should carefully define the kinds of facilities covered by the law and the kind of plastic or cosmetic surgery that Congress intends to impact.

AAAHC's accreditation program has only reached a small minority of ASCs and office-based surgical centers. At this time, AAAHC has accredited approximately 350 facilities including 112 ASCs and approximately 44 office-based surgery centers and practices. Of the office-based practices, 19 are either plastic or facial plastic facilities. AAAHC has also accredited an additional 24 surgical facilities whose Medicare certification status is unknown. Moreover, AAAHC has accredited a number of HMOs and large group practices that have Medicare-certified ASCs and/or office surgical suites as part of their operation that are not included in the separate counts given above.

There continues to be a growing interest among physicians in having their organizations accredited, especially among office surgery practices and ASCs. This interest in accreditation is growing due to several factors, including an increasing interest on the part of third party payors in paying for services rendered in the outpatient setting. Physicians and administrators are also very interested in improved quality of health care delivery and the accreditation program helps them organize and institute a system to monitor that health care delivery.

III. AAAHC's ACCREDITATION PROGRAM

AAAHC standards have evolved over a period of twenty years. The current 1989-90 edition of the Accreditation Handbook for ambulatory care represents the fifth edition since AAAHC was created in 1979. A copy of the 1989-1990 edition of the Handbook has been provided to the Subcommittee in conjunction with this testimony.

The standards are very comprehensive and cover 21 areas of concern. The first eight chapters are core standards and are applied to every organization. The subsequent chapters are applied to an organization if they provide those services. For example, an office surgical practice must meet the core standards, relating to Rights of Patients, Governance, Administration, Quality of Care, Quality Assurance Program, Clinical Records, Professional Improvement, and Facilities and Environment, and in addition must meet the standards on Anesthesia and Surgical Services. Standards relating to other areas, such as Pathology and Medical Laboratory Services and Diagnostic and Therapeutic Imaging are applicable if the office-based surgical practice provides such services.

Accreditation is a voluntary process. It begins with an application for survey which is completed by the organization seeking a survey. The organization then completes a self assessment, using a Self Assessment Manual, and begins to correct any areas that are in less than substantial compliance with the standards. A date for the survey is established with the organization, and AAAHC selects a survey team. The size of the survey team and the length of the survey is determined by the size and type of the organization. The minimum initial survey of an organization seeking accreditation is one and a half days in length and involves at least two physician surveyors. Typically, for an office-based surgical practice, the surgery team consist of either two surgeons specializing in the services provided by the facility, or one surgeon specializing in that area and one anesthesiologist. AAAHC stresses an interdisciplinary approach. Thus, the survey team for an office-based cosmetic practice would be drawn from a surveyor pool consisting of anesthesiologists, plastic surgeons, facial plastic surgeons, and general surgeons. For larger organizations, the survey teams may also include a nurse administrator, an operating room nurse or an administrator. All AAAHC surveyors must be trained to conduct surveys for AAAHC, and they are carefully screened to prevent any conflict of interest with the particular organization they survey.

Approximately four to six weeks prior to the survey, the organization completes a Presurvey Questionnaire and submits it to AAAHC along with other documents. This Questionnaire and other documents are reviewed prior to the on-site survey to provide the survey team with an accurate picture of the organization.

During the on-site survey, the survey team observes surgical procedures as they are being performed, reviews clinical (medical) records, reviews the organization's policies and procedures (including, for example, the organization's risk management, emergency and infection control procedures), reviews the organization's financial records, and reviews patient satisfaction questionnaires. Structured individual interviews are held with the key physicians and other personnel in the organization. Moreover, public notice of the survey is required before the survey occurs to allow interested individuals from the public time to request the opportunity to present information relevant to the survey. A detailed survey report is completed by the survey team.

At the end of the survey, the survey team presents its findings in a summation conference. Opportunity is provided for discussion and clarification of the findings. Following the survey, the survey team chairperson submits a complete survey report with findings and recommendations to the Accreditation Committee of the Board of Directors. This year, the Accreditation Committee's Chairman is a plastic surgeon. The Accreditation Committee also includes an anesthesiologist, an internist, a clinic administrator, a specialist in occupational medicine and an ophthalmologist. A facial plastic surgeon will join the Accreditation Committee in the near future.

AAAHC staff reviews the survey report and any other documents submitted by the organization and presents an independent recommendation to the Accreditation Committee for their consideration. The Accreditation Committee then renders a decision, awarding three year accreditation, one year accreditation, deferral, or non accreditation.

A number of the standards included in AAAHC's survey process may be of particular interest to the Subcommittee. First, we are aware that the Subcommittee is concerned that some office-based cosmetic surgical facilities are allegedly engaging in deceptive or misleading advertising. Criteria 1.H of AAAHC's standards regarding "Rights of Patients," requires that "marketing or advertising regarding the competence and capabilities of the organization cannot be misleading to patients." In addition, Standard 2.B.14, relating to Governance, requires that the governing body assure that all marketing and advertising do not imply that the organization provides care that it is not capable of providing. As part of the survey process, AAAHC's surveyors review the marketing and advertising materials distributed by a surveyed facility to ensure compliance with these standards, and AAAHC has insisted on corrective action where an organization's marketing materials have been found to be misleading to the public.

Second, AAAHC's standards also require accredited facilities to have a formal credentialling process through which the governing body makes decisions concerning the initial appointment, reappointment, and assignment or curtailment of medical privileges. The governing body is required to make such decisions in a manner which is consistent with state law and based on evidence of the education, training, experience, and current competence of the physician. Likewise, the facility is required to have a formal process for the initial appointment, reappointment, and assignment or curtailment of privileges for health care personnel and practitioners other than physicians. Where a surveyed facility is an office-based surgical practice owned and operated by a single physician, AAAHC's surveyors directly review the physician's credentials, training, and experience against the surgical procedures authorized to be performed in the facility, to ensure that the surgeon is qualified.

Third, AAAHC requires that an accredited organization must either have a written transfer agreement with a nearby hospital, or must permit elective surgery only by practitioners who have admitting privileges at a nearby hospital. This Standard (Standard 10.M) is crucial to the accreditation process.

Fourth, the standards relating to quality of care and quality assurance programs are the heart of AAAHC's accreditation program. An accredited facility's quality assurance program must address clinical, administrative, and cost-of-care issues, as well as actual or potential problems affecting patient outcomes. AAAHC requires physician monitoring of care on both a concurrent and a retrospective basis. Significantly, at least two physicians (or dentists in dental practices) must be involved in quality assurance activities in order to provide peer-based review. AAAHC's standards specifically require that in solo physician organizations, such as office-based surgical practices, an outside physician must be involved in quality assurance activities to provide peer-based review. AAAHC's requirements in this regard far exceed Medicare certification requirements.

Finally, AAAHC's requirements with regard to physical plant likewise meet or exceed Medicare certification requirements for ASCs. AAAHC-accredited facilities are required to meet life safety code requirements, and must meet all applicable licensure requirements. Accredited facilities also must have a comprehensive emergency plan, and personnel trained in cardiopulmonary resuscitation and the use of cardiac emergency equipment must be present in the facility during hours of operation. Standards 8.B.2 and 8.B.3.

In short, AAAHC's goal is to ensure not only adequate, but excellent care. AAAHC's standards and requirements far exceed the requirements of state licensure agencies and the Medicare certification requirements applicable to ASCs. AAAHC believes that it is imperative that it maintain these high standards to ensure that the stamp "Accredited by AAAHC," continues to communicate "quality" to patients served by accredited facilities and to the public at large.

IV. "MANDATORY" ACCREDITATION: A CONTRADICTION IN TERMS?

The voluntary nature of AAAHC's accreditation program has been fundamental to its philosophy since its inception. AAAHC was born out of the belief that a voluntary, pluralistic, peer-based approach is effective in improving health care services -- that such an approach fosters innovation and provides motivation. AAAHC's goals in accrediting facilities are to assist facilities in improving the quality of care they provide, and to educate facilities concerning the appropriate procedures and processes necessary to continue to provide high quality care. AAAHC's goal is not to sanction or regulate facilities: AAAHC accreditation has always been a carrot, not a stick. Moreover, AAAHC's accreditation program works because of the commitment and dedication of its surveyors -- all of whom are volunteers willing to dedicate their time and efforts to assisting others to assure high quality care. AAAHC does not believe that the quality of its surveyors could be duplicated in any mandatory system. Finally, AAAHC's goals are different than the goals of most regulatory systems. While most regulatory systems seek to ensure compliance with minimal standards of care, AAAHC seeks to ensure compliance with the highest quality standards.

AAAHC is not in a position to determine the need for additional federal regulation to address perceived deficiencies in the quality of care rendered by office-based cosmetic surgical practices. Generally, facilities which apply for accreditation are those dedicated to quality. Moreover, organizations applying for accreditation generally spend significant time and resources preparing for the accreditation survey. For these reasons, AAAHC does not have an extensive information base relating to substandard facilities.

AAAHC does believe, however, that if Congress concludes that some federal regulatory system is necessary to ensure compliance with minimal standards, such a regulatory system should explicitly provide for deemed status for AAAHC-accredited facilities. AAAHC standards meet or exceed Medicare certification requirements for ASCs; yet, thus far, the Health Care Financing Administration has failed to provide deemed status for AAAHC-accredited ASCs. AAAHC believes that by failing to implement a deemed-status mechanism, the federal government has failed to provide the proper incentive for facilities to become accredited. Thus, if this Subcommittee believes that federal legislation is necessary to establish minimal standards for cosmetic office-based surgical practices, such legislation should explicitly provide deemed status for AAAHC-accredited office-based facilities. Such legislation should also provide deemed status for AAAHC-accredited ASCs for Medicare certification purposes. These deemed-status provisions would provide the appropriate federal incentives for both office-based surgical practices and ASCs to meet AAAHC's high quality standards.

Finally, if the Subcommittee determines that federal legislation requiring the establishment of minimal standards is required to address perceived problems in the quality of care rendered by cosmetic and plastic surgery facilities, AAAHC would be pleased to work with the Subcommittee or the appropriate administrative agency to ensure that such standards are reasonable and appropriate. Over the past ten years, AAAHC has accumulated a wealth of experience concerning what constitutes quality in outpatient facilities, and we would be pleased to share that experience with the Subcommittee.

Again, we appreciate the opportunity to testify with regard to these most important issues, and would be delighted to provide any further information that may be useful to the Subcommittee.

Respectfully submitted,

Accreditation Association for
Ambulatory Health Care, Inc.

Carl Battaglia, M.D.

Carl Battaglia, M.D.
President

Ronald S. Moen

Ronald S. Moen
Executive Director

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Accreditation
Handbook
for Ambulatory
Health Care
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References are made throughout this *Handbook* to the *Life Safety Code®* and to NFPA 101®. Both are registered trademarks of the National Fire Protection Association, Quincy, Massachusetts.

The pronouns used in the *Handbook* were chosen for ease of reading. They are not intended to exclude reference to either sex.

Foreword

For the past ten years, the focus of health care delivery has shifted from the inpatient, institutional setting back to the ambulatory setting with an explosion of what is often referred to as the non-traditional or alternative delivery setting. Most health care has always been provided on an outpatient basis, but the costs associated with inpatient care in recent years have driven physicians, patients, and payors to critically examine the costs and benefits associated with large institutional settings.

Since 1979, the Accreditation Association for Ambulatory Health Care has been leading the way in the evaluation, accreditation, and recognition of high-quality ambulatory health care organizations. AAAHC has received enthusiastic support and endorsement of its program from providers, third party payors, government agencies, and members of the general public.

The standards published in this 1989-90 Edition of the *Accreditation Handbook for Ambulatory Health Care* represent over 20 years of effort by thousands of experts in the delivery of ambulatory health care services. The standards describe the features and characteristics that AAAHC believes are essential to the provision of high-quality care in a reasonable and prudent manner.

This 1989-90 *Handbook* is the fifth major revision of the standards that were first published in 1979, revised in 1982, 1985, and again in 1987. The standards change because the delivery of ambulatory health care changes. The revisions found in this edition, as in previous editions, reflect the experience, knowledge, and wisdom gained over the years by AAAHC's surveyors, staff, and accredited organizations, and through review and comment by many interested health care provider groups and the national health care associations represented on its Board of Directors.

All changes in this edition were carefully considered by the Board before adoption. Of the revisions, the most readily noticeable are the new chapters on Overnight Care and Dental Services and the separation of the chapter on Anesthesia from Surgical Services into two distinct chapters. Other revisions expand or clarify existing standards. Appendix A outlines the major changes and revisions for easy reference.

Also new to this edition is a checklist to aid organizations in assessing their own compliance with the Quality Assurance standard, and a worksheet to evaluate Clinical (Medical) Records. An additional appendix on features of a Risk Management Program is also included with this edition of the *Handbook* for the first time.

With the continued expansion of health care delivery in the ambulatory setting and through managed care systems, the standards of quality set by the AAAHC take on even greater significance to the profession and the public. The member organizations of AAAHC, its board, staff, and surveyors are committed to the continued evolution of a high-quality, peer-based, voluntary accreditation program for ambulatory health care and managed care systems. The comments and suggestions of interested individuals and organizations about our standards and survey program are always welcome.

This 10-year anniversary edition of the *Handbook* is dedicated to the men and women who by their volunteer efforts have made it possible for AAAHC to assume a leading role in the advancement of high-quality health care.

Carl J. Bottaglia, MD
President, AAAHC

Ronald S. Moen
Executive Director, AAAHC

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Accreditation Policies and Procedures

Consultation Services

AAAHC provides a consultation service for any organization desiring additional help in understanding the standards, preparing for accreditation, or achieving compliance with a particular standard. Consultation allows the participating organization to seek assistance in meeting specific needs. This includes specifying areas to be reviewed, as well as the number of consultants.

Workshops for large organizations with multiple sites, national prepaid or managed care systems, or state associations of various groups are also provided upon request, depending upon the availability of staff and surveyors. There is a fee for the consultation service and the workshops.

By definition, on-site consultation does not result in an accreditation decision. Problems are identified and recommendations for improvement are made, but all reports of findings are strictly for the use of the requesting organization. The consultation may be one or two days in length with one or more surveyor/consultants participating. Organizations may request specific surveyors (pending availability) and, whenever possible, surveyor/consultants will be from the organization's geographic region.

Consultation may be held any time the organization requests, provided the organization is open and operating. Consultation from AAAHC cannot be part of pre-construction or pre-opening planning. The fee for a consultation or workshop is based on the number of surveyor/consultants and the number of days of the on-site visit. AAAHC fees are determined on an annual basis.

Eligibility for Survey

Any organization that meets AAAHC's Survey Eligibility Criteria (see below) may apply for an accreditation survey. The following types of organizations have found the AAAHC standards and survey procedures particularly appropriate and helpful in improving the quality of care they provide:

Ambulatory health care clinics

Ambulatory surgery centers

Birthing centers

College and university health services

Community health centers

Dental group practices

Faculty medical practice plans

Health maintenance organizations and other prepaid or managed care systems

Hospital-sponsored ambulatory care clinics and surgery centers

Multi-specialty group practices

Networks and groups of ambulatory health care organizations

Occupational health services

Office surgery centers and practices

Single-specialty group practices

Surgical recovery centers

Urgent or immediate care centers

Survey Eligibility Criteria

An organization is eligible for an accreditation survey by the Accreditation Association for Ambulatory Health Care if it:

1. has been providing health care services for at least six months before the on-site survey (where a delay in survey for six months would cause a serious hardship for the organization, the applicant is requested to contact AAAHC in advance)

2. is either a formally organized and legally constituted entity that primarily provides health care services, or a subunit that primarily provides such services within a formally organized and legally constituted entity that may be, but need not be, health related

3. is in compliance with applicable federal, state (provincial), and local laws and regulations

4. is licensed by the state (province) in which it is located if the state requires licensure for that organization

5. provides medical care that is under the direction or supervision of a physician or group of physicians who accept responsibility for that medical care; or provides dental care that is under the direction or supervision of a dentist or group of dentists who accept responsibility for that dental care

6. shares the facilities, equipment, business management, and records involved in patient care among the members of the organization

7. operates without limitation because of race, creed, sex, or national origin

8. provides the signed application for survey, presurvey questionnaire, and other documents in advance of the survey

9. pays the appropriate fees

Organizations are considered for survey on an individual basis. The AAAHC determines whether the standards can be applied to any given applicant. If AAAHC decides that the standards cannot be applied, a survey will not be conducted. The AAAHC will inform the organization of the reason for such a decision and will refund the application fee. If a survey is conducted and AAAHC decides that the standards cannot be applied appropriately in order to reach an accreditation decision, the survey will be deemed to be a consultation and no accreditation decision will be made. Fees for such a consultation will not be refunded.

Purpose and Application of the Standards

The standards contained in the *Handbook* were developed to encourage the voluntary attainment of high-quality care in organizations providing health care services. The standards describe characteristics that the AAAHC believes to be indicative of an accreditable health care organization.

Most standards are written in general terms to allow an organization to achieve compliance in the manner that is most compatible with its particular situation and most conducive to the attainment of high-quality patient care. Where the acceptable methods of achieving compliance with a standard are limited, the standard is written in specific terms. Whether a standard is stated in general or specific terms, however, the AAAHC is concerned about compliance with the intent of the standard first and with the letter of the standard second.

Throughout the *Handbook*, reference is made to specific documents or standards published by other organizations. Subsequent editions of these publications become the authoritative reference of the AAAHC only after they have been approved as such by the Board of Directors.

All organizations seeking accreditation, regardless of name, mission statement, or primary service provided, must meet the same high standards described in the *Handbook*.

Regardless of the type of organization surveyed, the applicable portions of the chapters of Core standards titled Rights of Patients, Governance, Administration, Quality of Care Provided, Quality Assurance Program, Clinical Records, Professional Improvement, and Facilities and Environment will be applied to all organizations seeking survey. Other chapters will be applied as appropriate to the services provided by the organization.

For example, emergency centers and immediate/urgent care centers must be in compliance with the respective chapters in the *Handbook*, as well as in compliance with all Core standards, and others, such as laboratory and radiology services, if applicable.

Likewise, ambulatory surgical centers and office surgery practices must meet the Core standards, Anesthesia standards and Surgical Services standards, as well as all other relevant standards. Certain large multi-specialty group practices or hospital-sponsored ambulatory health care programs may find that all of the standards in the *Handbook* will be applicable. Any questions about the applicability of the standards should be addressed to the AAAHC offices.

Survey Process

Although the accreditation survey process is of necessity evaluative, the AAAHC emphasizes the educational and consultative benefits of accreditation. Consequently, the AAAHC uses administrators and health care practitioners who are actually practicing in ambulatory health care settings to conduct accreditation surveys. These dedicated individuals volunteer their time to be trained and to serve as surveyors. The primary objective of their training is to teach them to use their practical knowledge in the equitable application of the standards.

Each accreditation survey is tailored to the type, size, and range of services offered by the organization seeking accreditation. The length of the on-site visit and the number of surveyors used by AAAHC are based on a careful review of the information provided in the Application for Survey submitted by the organization.

Accreditation decisions are made by the Accreditation Committee of the Board of Directors after careful review of the recommendations and reports of surveyors and staff. Accreditation is awarded to organizations that demonstrate substantial compliance with the standards. The degree and number of variations in compliance, as well as the importance of a particular deficiency in a specific organization, determine the accreditation decision.

Principles Governing Accreditation Survey Procedures

The accreditation decision is based on a careful and reasonable assessment of an organization's compliance with applicable standards. While no organization can be expected to achieve total compliance with every standard, the AAAHC does expect substantial compliance with the applicable standards. The extent of compliance is assessed through at least one of the following means:

1. documented evidence
2. answers to detailed questions concerning implementation
3. on-site observations and interviews by surveyors

An accreditable organization will not be held in noncompliance with the standards if the governing body approves non-physician health practitioners to carry out specific examinations or procedures, order laboratory tests or radiological studies, provide treatment, or conduct or supervise health care services, so long as any of these activities are specifically authorized or mandated by state (provincial) law governing the practice of medicine or other health care practitioners.

Survey Procedures and Personnel

The survey of a health care organization is conducted by surveyors selected and trained by the AAAHC. Surveyors are physicians, dentists, nurses, and administrators who practice in ambulatory health care settings. Specific survey team members are selected, to the extent possible, on the basis of their knowledge of and experience with the range of services provided by the organization seeking survey, as well as with its type, size, and location.

The survey is conducted in accordance with written procedures sent to the organization before the on-site survey. These procedures enable the surveyors to gather information with minimal disruption of the daily activities of the organization being surveyed. Organizations will be asked in advance to have specified documents and other information available to the surveyors during the on-site visit. They will also be asked to submit other documents directly to the AAAHC in advance of the survey. Surveyors may, however, ask to see additional documents or may request additional information during the on-site survey.

At the conclusion of the on-site survey, the surveyors hold a summation conference at which they present their findings to representatives of the organization for discussion and clarification. Members of the organization's governing body, medical staff, and administration are encouraged to take this opportunity to comment on or rebut the findings as well as express their perceptions of the survey.

The report and recommendations of the surveyors and staff of AAAHC are then submitted to the AAAHC Accreditation Committee for review and decision as described later in the section titled Accreditation Decision and Notification.

Survey Forms

Organizations that have applied for survey will receive copies of all survey forms free of charge. The following survey forms, although designed primarily for organizations involved in the survey process, may be obtained by any interested individual by writing to the Accreditation Association for Ambulatory Health Care, Inc., 9933 N. Lawler Avenue, Skokie, IL 60077-3702 or by calling (312) 676-9610. After November 1, 1989, please call (708) 676-9610. There is a fee for the *Self Assessment Manual* and *Presurvey Questionnaire* as well as for the *Handbook*.

The Application for Accreditation Survey requires an organization to certify its compliance with survey eligibility criteria. It must be completed by each organization wishing to undergo survey. Except where prohibited by law, a nonrefundable application fee must accompany each *Application*.

The *Self Assessment Manual* enables an organization to evaluate its own compliance with the standards. Forms are provided to facilitate the assignment of various standards to the organization's staff for review, outline a chronological sequence in preparation for survey, and enable staff to focus on areas that are in less than substantial compliance with the standards. The *Self Assessment Manual* follows the same format used by AAAHC surveyors in completing a *Survey Report*.

The *Presurvey Questionnaire* enables AAAHC to assess the organization's governing structure and the extent and the type of health care services offered. It must be submitted prior to survey. Surveyors and staff will review the questionnaire and may request clarification of any information contained therein.

The *Survey Report Form* contains the survey findings, recommendations for improvement regarding the standards, and any consultative comments made by the surveyors to representatives of the organization during the survey.

The *Survey Evaluation Form* enables the surveyed organization to evaluate surveyor performance, the reasonableness of the standards, and the value of the consultation and education provided to the organization's staff. It also enables the organization to evaluate the survey process in terms of its effect on improving the quality of care provided.

Survey Fees and Schedules

The survey fee is based on the number of surveyors and the number of days required to complete the on-site evaluation. Except where prohibited by law, the survey fee must be paid 30 days in advance. An invoice will be sent approximately eight weeks prior to the survey.

If an organization cancels or postpones its survey in writing more than eight weeks before the survey, the entire fee will be refunded. If the organization cancels or postpones its survey in writing less than eight weeks before the survey, the AAAHC will refund the survey fee less any costs incurred in preparing for the survey.

If the survey fee was not paid in advance, and the organization cancels or postpones its survey in writing less than eight weeks before the survey, the AAAHC will bill the organization for costs incurred in preparing for the survey.

Survey dates are determined by AAAHC in cooperation with the organization being surveyed. Every attempt is made to schedule the survey at the most convenient time for the requesting organization.

Organizations with multiple service locations should be aware that AAAHC policy requires a significant sample of all service sites to be visited on the initial survey. Where organizations with multiple sites have achieved a full three-year accreditation, a sampling plan will be used for subsequent surveys. IPA and Network Model HMOs will also be surveyed using a sampling plan. AAAHC staff will determine which service sites will be reviewed during the survey. For further information, please contact the AAAHC office.

Compliance with Omnibus Reconciliation Act of 1980

For any health care organization that pays AAAHC $10,000 or more in any twelve-month period to comply with Section 952, PL 96-499, the Omnibus Reconciliation Act of 1980, the AAAHC hereby stipulates that only those AAAHC records, contracts, documents, or books that are necessary to verify the extent and nature of AAAHC costs will be available for four years after the survey, consultation, or contracted services are completed to the Secretary of the Department of Health and Human Services (DHHS), the Comptroller General of the United States, or any of their duly authorized representatives.

This stipulation is provided as a matter of policy by AAAHC in lieu of providing separate contracts for each affected organization. These same conditions will apply to any subcontracts AAAHC has with related organizations if such payments amount to $10,000 or more in any twelve-month period. This policy applies to all contracts, surveys, and AAAHC records as of December 5, 1980, and so long as these regulations remain in force.

Notice of Survey and Presentation of Information by Individuals

Once a survey has been scheduled, AAAHC sends to the organization to be surveyed a confirmation of the date(s) of the survey, the name(s) of the surveyors who will conduct the survey, the survey schedule, and other information about the review.

Public Notice of Survey Required

AAAHC policy requires that a notice of the date(s) of survey and opportunity for interested individuals to present relevant information be posted on the organization's premises in a manner intended to give public notice four weeks before the scheduled survey date(s). To assist organizations and to assure consistency in posting public notice, AAAHC sends to each organization to be surveyed copies of the Notice of Accreditation Survey form for posting.

If the organization refuses to post the notice before the survey, the survey will not be conducted. If the organization unintentionally fails to post the notice, the survey will be conducted but no accreditation decision will be made until the organization, within three months from the survey, posts the notice for four weeks. This is to allow interested individuals time to request the opportunity to present information relevant to the survey. If such a request is received, a surveyor will be sent, at the surveyed organization's expense, to receive the information.

Opportunity to Present Information

The AAAHC provides an opportunity during the on-site survey for members of the general public as well as patients and staff of the organization being surveyed to present to AAAHC surveyors pertinent and valid information about the surveyed organization's provision of health care or its compliance with AAAHC standards. Alternatively, individuals may present such information in writing or by telephone to AAAHC's headquarters.

All information received from identified individuals will be considered in the accreditation process.

Presentation of Information in Person

The opportunity for individuals to present information in person is usually scheduled during the morning of the first survey day and normally does not exceed one hour in length. The time and length of the session should be agreeable to all parties concerned, but final authority for such matters rests with the chairperson of the survey team. The surveyed organization will provide reasonable accommodations for the session, which is chaired by the AAAHC surveyor. At least one representative of the surveyed organization must attend the session.

The session will consist only of the orderly presentation of information, verbally or in writing, within the prescribed time limit. All information received will be considered for pertinence and accuracy and the findings may be included in the survey report if applicable.

Requests to Present Information

A request to present information during the on-site survey must be received at least two weeks before the survey date(s) to allow time to schedule the session. The organization surveyed will refer to AAAHC any such requests it receives. AAAHC will acknowledge each and send a copy of the acknowledgement to the surveyed organization. Requests received directly by AAAHC will be acknowledged in the same manner. The surveyed organization is responsible for informing the requesting individual of the date, time, and place for the presentation of information to the surveyors.

Accreditation Decision and Notification

After the on-site survey is completed, AAAHC staff members review the survey report, surveyor recommendations, including the survey team's overall recommendation regarding accreditation, any other relevant information, and make a recommendation regarding accreditation to the Accreditation Committee of the AAAHC. The committee carefully reviews each survey report, surveyor and staff recommendations, and any other relevant information before making a decision. A surveyor, staff member, or member of the AAAHC Board of Directors who is in any way affiliated with an organization or whose participation represents a conflict of interest is not allowed to participate in deliberations or voting relative to the accreditation status of that organization. A decision of the Accreditation Committee to accredit an organization is final.

Duration of Accreditation

The Accreditation Committee awards an organization accreditation for three years when it concludes that the organization is in substantial compliance with the standards, and the committee has no reservations about the accuracy of the survey findings or the organization's commitment to continue providing high-quality care and services as reflected in the standards.

The Accreditation Committee awards an organization accreditation for one year when it concludes that the organization is in substantial compliance with the standards but either the organization's compliance appears to be pro forma or not well established or the organization's commitment to one or more of the standards appears shallow or short-lived.

The AAAHC may conclude that the factors that resulted in accreditation for one year are such that the organization may request a special on-site review within one year from the previous survey date, without payment of an additional application fee. Such a special on-site review may be conducted by one or more surveyors in a visit to the organization at the prevailing fee. The on-site review will not necessarily be limited to the recommendations in the survey report.

An accredited organization may be resurveyed with or without advance notice at any time at the discretion of the AAAHC. No fee shall be charged the organization when such a resurvey is initiated at the discretion of the AAAHC. If an accredited organization is surveyed by the AAAHC and is judged not to be in substantial compliance with the standards, its accreditation will be revoked.

Deferred Accreditation Decision

The Accreditation Committee may defer an accreditation decision when it concludes that the organization is in less than substantial compliance with one or more standards and it demonstrates the commitment and capability to correct the identified deficiencies within six months. In such cases, the organization may request another on-site survey without paying an additional application fee. This request must be made within six months of notification of the deferred accreditation decision. The on-site survey may be conducted in a visit at the prevailing fee and will not necessarily be limited to the recommendations in the initial survey report.

IF AN ORGANIZATION WHOSE ACCREDITATION DECISION IS DEFERRED DOES NOT REQUEST AN ON-SITE RESURVEY WITHIN SIX MONTHS OF NOTIFICATION OF DEFERRAL, THE ORGANIZATION WILL BE DEEMED NON-ACCREDITED.

Denial of Accreditation

The Accreditation Committee denies accreditation to an organization when it concludes that the organization is not in substantial compliance with the standards. An organization that is not granted accreditation or that has its accreditation revoked may apply for resurvey at any time following the decision.

Appeal of Accreditation Decision

Any decision of the Accreditation Committee may be appealed by following the procedures outlined in Appendix B, Appeal of Accreditation Decision.

Notification of Decision

The AAAHC notifies an organization of the Accreditation Committee's decision by mail promptly following the committee's meeting. Copies of the survey report are sent to the head of the governing body, the chief medical executive, and the administrator of the organization.

Transfer of Accreditation

Accreditation is not automatically transferable when an accredited organization changes ownership or control, such as a merger or consolidation. The AAAHC must be advised within 30 days of any such change as required by Standard 2.C.3. If AAAHC decides that a resurvey is necessary, the organization must submit an Application for Accreditation Survey with the required fee within 20 days of notification by the AAAHC. Failure to comply with these provisions may result in the loss of accreditation.

Public Recognition

AAAHC-accredited organizations are encouraged to publicly display the certificate of accreditation provided by AAAHC. The certificate and all copies remain the property of the AAAHC and must be returned if the organization is issued a new certificate reflecting a change in name or services for which it is accredited, or if it loses its accreditation for any cause.

The AAAHC will periodically publish and distribute lists of organizations that have been awarded accreditation. In addition, the AAAHC will, upon request, disclose receipt of an application for the survey, the dates of a survey, the status of the decision process, or the final decision.

Confidentiality

Except as required by law, the AAAHC will not release any information obtained through the survey of any organization without the organization's written authorization.

In submitting its Application for Accreditation Survey, the organization either provides or authorizes the AAAHC to obtain required official records and reports of public or publicly recognized licensing, examining, reviewing, or planning bodies.

Except as indicated above, the contents of the survey report are provided only to the surveyed organization and are disseminated solely at its discretion.

Rights of Patients

An accreditable organization recognizes the basic human rights of patients. Such an organization has the following characteristics.

A. Patients are treated with respect, consideration, and dignity.

B. Patients are provided appropriate privacy.

C. Patient disclosures and records are treated confidentially, and, except when required by law, patients are given the opportunity to approve or refuse their release.

D. Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

E. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

F. Information is available to patients and staff concerning:

1. patient rights, including those specified in A, B, C, D, and E above
2. patient conduct and responsibilities
3. services available at the organization
4. provisions for after-hours and emergency care
5. fees for services
6. payment policies
7. patient's right to refuse to participate in experimental research
8. methods for expressing grievances and suggestions to the organization.

G. Patients are informed of their right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

H. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

Governance

2

An accreditable organization has a governing body that sets policy and is responsible for the organization. Such an organization has the following characteristics.

A. The organization is a legally constituted entity in the state(s) or province(s) in which it is located and provides services. The organization is constituted by at least one of the following:

1. charter
2. articles of incorporation
3. partnership agreement
4. franchise agreement
5. legislative or executive act.

B. The governing body addresses and is fully responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to,

1. determining the mission, goals, and objectives of the organization
2. assuring that facilities and personnel are adequate and appropriate to carry out the mission
3. establishing an organizational structure and specifying functional relationships among the various components of the organization
4. adopting bylaws or similar rules and regulations for the orderly development and management of the organization
5. adopting policies and procedures necessary for the orderly conduct of the organization
6. assuring that the quality of care is evaluated and that identified problems are appropriately addressed
7. reviewing all legal and ethical matters concerning the organization and its staff and, when necessary, responding appropriately
8. maintaining effective communication throughout the organization
9. establishing a system of financial management and accountability appropriate to the organization
10. determining a policy on the rights of patients
11. approving all major contracts or arrangements affecting the medical and dental care provided under its auspices, including but not limited to those concerning
    a. the employment of practitioners
    b. the provision of radiology services and pathology and medical laboratory services
    c. the use of external laboratories
    d. the provision of care by other health care organizations, such as hospitals
    e. the provision of education to students and postgraduate trainees.
12. formulating long-range plans in accordance with the mission, goals, and objectives of the organization
13. operating the organization without limitation because of race, creed, sex, or national origin
14. assuring that all marketing and advertising concerning the organization do not imply that it provides care or services that it is not capable of providing
15. developing a program of risk management appropriate to the organization including, but not limited to, the elements specified in Appendix D of this *Handbook*
16. determining a policy on continued education for personnel.

C. The governing body provides for full disclosure of ownership.

1. The names and addresses of all owners or controlling parties (whether individuals, partnerships, trusts, corporate bodies, or subdivisions of other bodies, such as public agencies or religious, fraternal, or other philanthropic organizations) are furnished to the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

2. For corporations, the names and addresses of all officers, directors, and principal stockholders, either beneficial or of record, are available to the public upon request and are furnished to the AAAHC.

3. Accredited organizations must notify AAAHC within 30 days of any significant change in ownership (such as a merger, change in majority interest, consolidation), name change, scope of services, or additional services or locations.

D. The governing body meets at least annually and keeps such minutes or other records as may be necessary for the orderly conduct of the organization.

E. If the governing body elects, appoints, or employs officers and administrators to carry out its directives, the authority, responsibility, and functions of all such positions are defined.

F. When a majority of its members are physicians, the governing body, either directly or by delegation, makes (in a manner consistent with state or provincial law and based on evidence of the education, training, experience, and current competence of the physician) the initial appointment, reappointment, and assignment or curtailment of medical privileges. When a majority of the members of the governing body are not physicians,the organization's bylaws or similar rules and regulations specify a procedure for establishing medical review for the purpose of making (in a manner consistent with state or provincial law and based on evidence of the education, training, experience, and current competence of the physician) initial appointment, reappointment, and assignment or curtailment of medical privileges.

G. Organizations that provide only dental services, or subunits that provide dental services within other organizations, provide a peer review mechanism to determine the initial appointment, reappointment, and assignment or curtailment of dental privileges in a manner consistent with state or provincial law and based on evidence of the education, training, experience, and current competence of the dentist.

H. The governing body provides (in a manner consistent with state or provincial law and based on evidence of education, training, experience, and current competence) for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for health care personnel and practitioners other than physicians or dentists.

Administration

3

An accreditable organization is administered in a manner that assures the provision of high-quality health services and that fulfills the organization's mission, goals, and objectives. Such an organization has the following characteristics.

A. Administrative policies, procedures, and controls are established and implemented to assure the orderly and efficient management of the organization. Administrative responsibilities include, but are not limited to,

1. enforcing policies delegated by the governing body
2. employing qualified management personnel
3. long-range and short-range planning for the needs of the organization, as determined by the governing body
4. taking all reasonable steps to comply with applicable laws and regulations
5. protecting the assets of the organization
6. implementing fiscal controls including, but not limited to,
    a. authorization and record procedures that are adequate to provide accounting controls over assets, liabilities, revenues, and expenses
    b. policies and procedures for controlling accounts receivable and accounts payable and for handling cash and credit arrangements
    c. rates and charges for services provided by the organization
7. using methods of communicating and reporting designed to assure the orderly flow of information within the organization
8. controlling the purchase, maintenance, and distribution of the equipment, materials, and facilities of the organization
9. establishing lines of authority, accountability, and supervision of personnel
10. establishing controls relating to the custody of the official documents of the organization
11. maintaining the confidentiality, security, and physical safety of data on patients and staff.

B. Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization. Personnel policies

1. define and delineate functional responsibilities and authority
2. require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification
3. require periodic appraisal of each person's job performance
4. describe incentives and rewards
5. require periodic review of employee compensation
6. specify responsibilities and privileges of employment
7. are made known to employees at the time of employment.

C. The organization periodically assesses patient satisfaction with services and facilities provided by the organization. The findings are reviewed by the governing body and, when appropriate, corrective actions are taken.

D. When students and postgraduate trainees are present, their status is defined in the organization's personnel policies.

Quality of Care Provided

An accreditable organization provides high-quality health care services in accordance with the principles of professional practice and ethical conduct, and with concern for the costs of care. Such an organization has the following characteristics.

A. All health care practitioners have the necessary and appropriate training and skills to deliver the services provided by the organization.

B. Health care practitioners practice their professions in an ethical and legal manner.

C. All personnel assisting in the provision of health care services are appropriately trained, qualified, and supervised and are available in sufficient numbers for the care provided.

D. The provision of high-quality health care services is demonstrated by at least the following:

1. education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures, and use of the health care system
2. accessible and available health services
3. appropriate and timely diagnosis based on findings of the initial assessment (history and physical examination)
4. treatment that is consistent with clinical impression or working diagnosis
5. appropriate and timely consultation
6. absence of clinically unnecessary diagnostic or therapeutic procedures
7. appropriate and timely referrals
8. appropriate and timely follow-up of findings and tests
9. patient cooperation
10. continuity of care
11. provision for services when the organization's facilities are not open
12. appropriate, accurate, and complete clinical record entries
13. adequate transfer of information when patients are transferred to and from other health care providers
14. patient satisfaction.

E. When clinically indicated, patients are contacted as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings that have been identified.

F. When the need arises, patients are transferred from the care of one health care practitioner to another.

1. Adequate specialty consultation services are available by prior arrangement.
2. Referral to a health care practitioner is clearly outlined to the patient and arranged with the accepting health care practitioner prior to transfer.

G. Concern for the costs of care is demonstrated by the following:

1. the relevance of health care services to the needs of the patients
2. the absence of duplicative diagnostic procedures
3. the appropriateness of treatment frequency
4. the use of the least expensive alternate resources when suitable
5. the use of ancillary services that are consistent with patients' needs.

H. When the need arises, provisions are made for health care practitioners and other staff to communicate with patients in the language primarily used by them.

Quality Assurance Program

5

In striving to improve the quality of care and to promote more effective and efficient utilization of facilities and services, an accreditable organization maintains an active, organized, peer-based, quality assurance program as an integral part of professional and administrative practice. Such an organization has the following characteristics.

A. The professional and administrative staff understands, supports, and participates in the quality assurance program, through an organized mechanism responsible to the governing body.

B. At least two physicians (or dentists in dental practices) are involved in quality assurance activities in order to provide peer-based review. (In solo physician or dental organizations, such as office-based surgical practices, independent practice associations, and dental practices, an outside physician or dentist is involved in quality assurance activities to provide peer-based review.)

C. The quality assurance program addresses clinical, administrative, and cost-of-care issues, as well as actual or potential problems affecting patient outcomes (results of care). Exclusive concentration on administrative or cost-of-care issues does not fulfill this requirement.

D. Quality assurance activities conducted by specific clinical disciplines within the organization (individual medical specialties, nursing, and so forth) are consistent with the characteristics of the organization's overall quality assurance program.

E. The organization provides ongoing monitoring of important aspects of the care provided.

F. Health care practitioners participate in the development and application of the criteria used to evaluate the care they provide.

G. Data related to established criteria are collected in an ongoing manner.

H. Collected data are periodically evaluated to identify unacceptable or unexpected trends or occurrences that influence patient outcomes (results of care).

I. Quality assurance activities have the following characteristics.

1. Important problems or concerns in the care of patients are identified. Sources of identifiable problems include, but are not limited to,
    a. unacceptable or unexpected results of ongoing monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal test results, radiology film retakes, prescribing errors for medications, specific diagnoses, and so forth
    b. the clinical performance and practice patterns of health care practitioners
    c. medical record review for quality of care and completeness of entries
    d. quality controls for and use of diagnostic imaging, pathology, medical laboratory, and pharmaceutical services
    e. other professional and technical services provided
    f. assessment of patient satisfaction
    g. direct observation
    h. staff concerns
    i. accessibility
    j. medical/legal issues
    k. wasteful practices
    l. over utilization and under utilization.
2. The frequency, severity, and source of suspected problems or concerns are evaluated. Health care practitioners participate in the evaluation of the problems or concerns identified.
3. Measures are implemented to resolve important problems or concerns that have been identified. Health care practitioners as well as administrative staff participate in the resolution of the problems or concerns that are identified.
4. The problems or concerns are reevaluated to determine objectively whether the corrective measures

have achieved and sustained the desired result. If the problem remains, alternate corrective actions are taken as needed to resolve the problem.

5. Through the organization's designed mechanisms, quality assurance activities are reported, as appropriate, to the proper personnel, the chief executive officer, and the governing body.

J. To permit flexibility and encourage innovation and variation, no particular method of conducting quality assurance activities is specified or required for accreditation. However, exclusive concentration on ongoing monitoring of care, without evidence of resolving problems, does not fulfill this standard.

K. Findings of quality assurance activities are incorporated into the organization's educational activities.

L. Appropriate records of quality assurance activities are maintained.

Clinical Records

6

An accreditable organization maintains a clinical record system from which information can be retrieved promptly. Clinical records are legible, documented accurately in a timely manner, and readily accessible to health care practitioners. Such an organization has the following characteristics.

A. The organization develops and maintains a system for the collection, processing, maintenance, storage, retrieval, and distribution of patient records.

B. An individual clinical record is established for each person receiving care.

C. All clinical information relevant to a patient is readily available to authorized health care practitioners anytime the organization is open to patients.

D. Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

E. There is a person designated in charge of clinical records whose responsibilities include, but are not limited to,

1. the confidentiality, security, and physical safety of records
2. the timely retrieval of individual records upon request
3. the unique identification of each patient's record
4. the supervision of the collection, processing, maintenance, storage, retrieval, and distribution of records
5. the maintenance of a predetermined organized record format.

F. Policies concerning clinical records address, but are not limited to,

1. the retention of active records
2. the retirement of inactive records
3. the timely entry of data in records
4. the release of information contained in records.

G. Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform.

H. Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) are reviewed and incorporated into the record in a timely manner.

I. If a patient's record is complex and lengthy, a summary of significant past surgical procedures as well as past and current diagnoses or problems is conspicuously documented in that patient's record to facilitate the ongoing provision of rational care. The summary is legibly recorded in the same location in all patient charts. The summary does not repeat problems or diagnoses that recur during ongoing treatment. The summary includes, but is not limited to,

1. significant surgical conditions, including major procedures
2. significant medical conditions, including medical diagnoses of conditions for which the patient receives medication or treatment on a repeated or continuing basis
3. conditions that are likely to significantly influence future care.

If a patient's record is not complex and lengthy, the record should contain appropriate and adequate information to facilitate the ongoing provision of rational care.

J. The presence or absence of allergies and untoward reactions to drugs is recorded in a prominent and uniform location in all patient charts on a current basis.

K. Entries in a patient's record for each visit include, but are not limited to,

1. date, department (if departmentalized), and provider name and profession (for example, PT, MD, RN, and so forth)
2. chief complaint or purpose of visit
3. clinical findings
4. diagnosis or impression
5. studies ordered, such as laboratory or x-ray studies
6. therapies administered
7. disposition, recommendations, and instructions given to the patient
8. signature or initials of practitioner.

L. Significant advice given to a patient by telephone is entered in the patient's record and appropriately signed or initialed.

M. Entries in a patient's record are legible to the clinical personnel in the organization.

N. Any notation in a patient's record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.

O. When necessary for assuring continuity of care, summaries or records of a patient who was treated elsewhere (such as by another physician, hospital, ambulatory surgical service, nursing home, or consultant) are obtained.

P. When necessary for assuring continuity of care, summaries of the patient's records are transferred to the health care practitioner to whom the patient was referred and, if appropriate, to the organization where future care will be rendered.

Note: *This chapter was changed from Medical Records to Clinical Records to reflect its application to surgical recovery centers, dental services, mental health services, oral and maxillofacial surgery, and other clinical areas where the person providing care may not be a physician. However, nothing in this chapter should be construed to dilute or otherwise alter a physician's responsibility for medical care and services provided by the organization.*

Professional Improvement

7

An accreditable organization strives to improve the professional competence and skill, as well as the quality of performance, of the health care practitioners and other professional personnel it employs. Such an organization has the following characteristics.

A. The organization provides for convenient access to library services that include materials pertinent to the clinical, educational, administrative, and research services offered by the organization.

B. The organization provides adequate orientation and training to familiarize all personnel with the organization's policies, procedures, and facilities.

C. The organization encourages participation in seminars, workshops, and other educational activities pertinent to its mission, goals, and objectives.

D. When attendance at educational activities is required of professional personnel, the organization accepts evidence of participation in relevant external educational programs.

E. The organization provides a monitoring function to assure the continued maintenance of licensure and/or certification of professional personnel.

Facilities and Environment

An accreditable organization provides a functionally safe and sanitary environment for its patients, personnel, and visitors. Such an organization has the following characteristics.

A. The organization assures that its facilities

1. comply with applicable state (or provincial) and local building codes and regulations
2. comply with applicable state (or provincial) and local fire prevention regulations
3. comply with applicable federal regulations
4. are inspected at least annually by the local or state (provincial) fire control agency, if this service is available in the community
5. contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type
6. have prominently displayed illuminated signs with emergency power capability at all exits from each floor or hall
7. have emergency lighting, as appropriate to the facility, to provide adequate evacuation of patients and staff in case of an emergency
8. have stairwells protected by fire doors.

B. The organization has the necessary personnel, equipment, and procedures to handle medical and other emergencies that may arise in connection with services sought or provided. At a minimum the organization provides

1. periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment
2. a comprehensive emergency plan to address internal and external emergencies, including
    a. a provision for the safe evacuation of patients during an internal emergency, especially patients who have difficulty walking
    b. a provision for the most efficient use of available facilities and services during an external emergency
    c. a requirement for at least four drills a year of the internal emergency plan
3. personnel trained in cardiopulmonary resuscitation and the use of cardiac emergency equipment present in the facility during hours of operation.

C. Smoking is prohibited in such areas as operating rooms, anesthetizing locations, rooms where oxygen and other volatile gases are administered or stored, and other hazardous areas. Smoking is permitted only in designated areas.

D. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are eliminated.

E. Reception areas, toilets, and telephones are provided in accordance with patient and visitor volume.

F. When appropriate, adequately marked patient and visitor parking is provided.

G. Provisions are made to reasonably accommodate handicapped individuals.

H. All examination rooms, dressing rooms, and reception areas are constructed and maintained in a manner that assures patient privacy during interviews, examinations, treatment, and consultation.

I. Adequate lighting and ventilation are provided in all areas.

J. Facilities are clean and properly maintained.

K. Food, snack services, and refreshments provided to patients meet their clinical needs and are prepared, stored, served, and disposed of in compliance with local health department requirements.

L. Procedures should be available to minimize the sources and transmission of infections, including adequate surveillance techniques.

M. A system exists for the proper identification, management, handling, transport, treatment, and disposition of hazardous materials and wastes whether solid, liquid, or gas.

1. This system includes, but is not limited to, infectious, radioactive, chemical, and physical hazards.
2. The system provides for the protection of patients, staff, and the environment.

N. The space allocated for a particular function or service is adequate for the activities performed therein, including space allocated for pathology and medical laboratory services, radiology services, pharmaceutical services, examination and treatment rooms, offices, operating rooms, recovery areas, storage rooms, reception areas, clinical records, and other special function areas.

O. Appropriate emergency equipment and supplies are maintained and readily accessible to all areas of each patient care service site.

P. Equipment is properly maintained and periodically tested.

Q. Alternate power, adequate for the protection of the life and safety of patients and staff, is available. Special attention is given to:

1. operative and recovery areas for surgical services;
2. treatment areas where emergency services are provided.

R. New facilities constructed by accreditable organizations comply with Section 12-6 "New Ambulatory Health Care Centers," Chapter 26, and other sections as may be applicable, of the 1985 edition of the *Life Safety Code*® (NFPA 101®), published by the National Fire Protection Association, Inc., unless otherwise provided for by state law, local code, or appropriate jurisdiction having authority.*

S. Existing facilities of accreditable organizations will, over a reasonable period of time, be brought into compliance with Section 13-6 "Existing Ambulatory Health Care Centers," Chapter 27, and other sections as may be applicable, of the 1985 edition of the *Life Safety Code*® (NFPA 101®), published by the National Fire Protection Association, Inc., unless otherwise provided for by state law, local code, or appropriate jurisdiction having authority.*

Note: *Organizations that were in compliance with the 1981 edition when they first achieved accreditation will not be downgraded if they do not meet some aspect of the 1985 edition. Unless otherwise required by federal programs (such as Medicare) or state or provincial requirements (such as licensing requirements), organizations are encouraged to construct new facilities or remodel existing facilities in compliance with the most recent (1988) edition of the* Life Safety Code. *Organizations should consult with their architects, engineers, and state (provincial) licensing agencies for current requirements.*

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*Life Safety Code® *and NFPA 101® are registered trademarks of the National Fire Protection Association, Inc., Quincy, Massachusetts.*

Anesthesia Services

Anesthesia services in an accreditable organization are provided in a safe and sanitary environment by qualified health care practitioners who have been granted privileges to provide those services by the governing body. Such an organization has the following characteristics.

A. Anesthesia services provided in the facilities owned or operated by the organization are limited to those techniques that are approved by the governing body upon the recommendation of qualified professional personnel.

B. Adequate supervision of anesthesia services provided by the organization is the responsibility of one or more qualified physicians or dentists (for dental services) who are approved by the governing body upon the recommendation of qualified professional personnel.

C. Policies and procedures are developed for anesthesia services that include, but are not limited to,

1. education, training, and supervision of personnel
2. responsibilities of non-physician anesthetists
3. responsibilities of supervising physicians or dentists

D. Anesthesia is not administered unless the operating surgeon, anesthesiologist, or dentist has evaluated the patient immediately prior to surgery to assess the risk of the anesthesia relative to the surgical procedure to be performed.

E. Anesthesia is administered by anesthesiologists, other qualified physician or dentist anesthetists, qualified nurse anesthetists, or supervised trainees in an approved educational program.

F. Intraoperative physiologic monitoring must, as a minimum, include the use of a pulse oximeter.

G. Patients who have received anesthesia are evaluated by the operating surgeon, anesthesiologist, or dentist after recovery from anesthesia, prior to discharge.

H. A person qualified to provide anesthesia services is available as long as clinically indicated.

I. Patients who have received anesthesia are discharged in the company of a responsible adult.

J. No patient shall receive general anesthesia unless one or more additional health care practitioners besides the one performing surgery are present or immediately available.

K. All machines in use for general anesthesia shall have not less than one annual functional testing by technicians with appropriate training and a log of this testing will be maintained.

Note: *This chapter will not be applied to organizations where the physicians and dentists are using only unsupplemented local anesthesia and/or inhaled nitrous oxide in low concentrations (not to exceed 50%).*

If an organization is using supplemented local anesthesia (i.e., local anesthesia accompanied by intravenous sedation involving sedatives, narcotics, or tranquilizers) or intravenous block anesthesia, standards A-I apply.

If an organization is using general anesthesia, all standards apply.

Surgical Services

10

Surgical services in an accreditable organization are performed in a safe and sanitary environment by qualified practitioners who have been granted privileges to perform those procedures by the governing body. Such an organization has the following characteristics.

A. Surgical procedures performed in the facilities owned or operated by the organization are limited to those procedures that are approved by the governing body upon the recommendation of qualified medical personnel.

B. Adequate supervision of surgery conducted in the organization is a responsibility of the governing body, is recommended by an anesthesiologist or another physician, and is provided by appropriate personnel.

C. Surgical procedures are performed only by health care practitioners who

1. are licensed to perform such procedures within the state (province) in which the organization is located
2. have been granted privileges to perform those procedures by the governing body of the organization, in accordance with standard 2.F or 2.G.

D. Surgical procedures to be performed in an office surgical practice are reviewed periodically as part of the peer review portion of the organization's quality assurance program.

E. An appropriate and current history, physical examination, and pertinent preoperative diagnostic studies are incorporated into the patient's record prior to surgery.

F. The necessity or appropriateness of the proposed surgery, as well as any available alternative treatment techniques, have been discussed with the patient prior to scheduling for surgery.

G. Registered nurse(s) and other personnel assisting in the provision of surgical services are appropriately trained and supervised and are available in sufficient numbers for the surgical and emergency care provided.

H. Each operating room is designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all persons in the area. At least one operating room is available for surgery.

Only nonflammable agents are present in an operating room, and the room is constructed and equipped in compliance with standards established by the National Fire Protection Association (NFPA 56G, Standard for Inhalation Anesthetics in Ambulatory Care Facilities, 1980) and with applicable state (provincial) and local fire codes.

I. An anesthesiologist, another physician, or dentist qualified in resuscitative techniques is present or immediately available until all patients operated on that day have been discharged.

J. With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient's record.

K. The findings and techniques of an operation are accurately and completely written or dictated immediately after the procedure by the health care practitioner who performed the operation. This description is immediately available for patient care and becomes a part of the patient's record.

L. A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, is assured through the provision of adequate space, equipment, and personnel.

1. Provisions have been made for the isolation or immediate transfer of patients with communicable disease.

2. All persons entering operating rooms are properly attired.

3. Acceptable aseptic techniques are used by all persons in the surgical areas.

4. Only authorized persons are allowed in the surgical area.

5. Suitable equipment for rapid and routine sterilization is available to assure that operating room materials are sterile.

6. Sterilized materials are packaged and labeled in a consistent manner to maintain sterility and identify sterility dates.

7. Environmental controls are implemented to assure a safe and sanitary environment.

8. Suitable equipment is provided for the regular cleaning of all interior surfaces.

9. Operating rooms are appropriately cleaned before each operation.

M. When hospitalization is indicated or to evaluate, stabilize, and transfer when emergencies or unplanned outcomes occur, the organization either has a written transfer agreement for transferring patients to a nearby hospital or permits elective surgery only by practitioners who have admitting and similar surgical privileges at a nearby hospital.

N. Procedures have been developed for obtaining blood and blood products on a timely basis.

O. Emergency power adequate for the type of surgery performed is available in operative and recovery areas.

P. Periodic calibration and/or preventive maintenance of equipment is provided.

Q. The informed consent of the patient or, if applicable, of the patient's representative is obtained before an operation is performed.

R. A procedure has been established for the observation and care of the patient during the preoperative preparation and postoperative recovery period.

S. Protocols have been established for instructing patients in selfcare after surgery, including written instructions to be given to patients who receive regional and general anesthesia.

Overnight Care and Services

11

If an accreditable organization provides overnight care and related services, such care and services meet the needs of the patients served and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. The scope and limitations of overnight care and services are clearly specified. Such information is communicated to

1. physicians who refer and admit patients to the program
2. staff who provide the care and services
3. potential patients in advance of their referral to the program
4. other health care providers and relevant community agencies.

B. Adequate supervision of overnight care and services is the responsibility of one or more qualified physicians who are approved by the governing body upon the recommendation of qualified medical personnel.

1. At least one physician is present or immediately available by telephone at any time patients are present.
2. A patient is admitted or discharged only upon the order of a physician who is responsible for the medical care of that patient.

C. Health care practitioners may admit patients to this program if they

1. are licensed to treat patients or supervise care and services in this setting
2. have been granted such privileges by the governing body of the organization in accordance with standard 2.F or 2.G.

D. Policies and procedures are clearly specified that include, but are not limited to,

1. clinical criteria for determining eligibility for admission
2. clinical responsibility for patients during their stay
3. arrangements for emergency services
4. arrangements for transfer to other health care services as needed.

E. The organization has a written transfer agreement with a nearby hospital or only grants admitting privileges to physicians who have admitting privileges at a nearby hospital.

F. The overnight care unit meets applicable local and state (or provincial) codes including licensing requirements if the state (province) licenses such units.

G. Registered nurse(s) and other personnel are appropriately trained and supervised and are available in sufficient numbers to meet patient needs.

H. At least one registered nurse is on duty at all times when patients are present.

I. Treatment rooms are provided or made available to meet patient needs and physician requirements.

J. Emergency power adequate for the size of the unit is available to protect the life and safety of patients.

K. Appropriate isolation procedures are followed when any patient is admitted with a suspected or diagnosed communicable disease.

L. Food service is provided to meet the needs of patients.

1. Food is purchased, stored, prepared, and served in compliance with local health department requirements.
2. Special dietary requirements for patient care are met.

3. Personnel providing food services shall meet local health department requirements.

M. In addition to the applicable Clinical Records requirements found in Chapter 6 of this *Handbook*, the records for overnight care and services shall include

1. a current history and physical examination
2. treatment orders
3. nursing notes
4. follow-up instructions to patients.

N. If overnight care is the only service provided by the organization, that organization shall meet all other applicable standards contained in this *Handbook*.

O. Where overnight care is only one of many services provided by the organization, these services shall be functionally integrated to assure compliance with all other applicable standards contained in this *Handbook*.

P. Overnight care and services are reviewed as part of the organization's quality assurance program.

Note: *This chapter applies to organizations, or subunits thereof, that provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery, require observation by medical personnel, be receiving treatment for non-critical illnesses, or need only short term or custodial care.*

Dental Services

12

Dental services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Dental services provided or made available are appropriate to the needs of the patients.

B. Dental records are maintained according to the requirements found in Chapter 6, Clinical Records, of this *Handbook*.

C. Anesthesia provided or made available shall meet the standards contained in Chapter 9, Anesthesia Services, of this *Handbook*.

D. Personnel providing dental services are prepared to evaluate, stabilize, and transfer medical emergencies that may occur or arise in conjunction with services provided by the organization.

Note: *Organizations providing dental services may obtain copies of generic protocols on important areas of patient care from the American Academy of Dental Group Practice, 5110 N. 40th Street, Phoenix, AZ 85018. Telephone 602/381-1185. These protocols will assist organizations that are seeking accreditation for their dental services to evaluate and improve the quality of care they provide.*

Emergency Services

If an accreditable organization implies by its activities, advertising, or practice that it provides emergency services on a regular basis to meet life, limb, or function-threatening conditions, such services meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Emergency services are provided twenty-four hours per day every day of the year.

B. Emergency services are performed only by health care practitioners who are licensed to perform such procedures within the state (province) in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical personnel and after medical review of the practitioner's documented education, training, experience, and current competence.

C. At least one qualified physician is present at all times.

D. Personnel assisting in the provision of emergency services are appropriately qualified, trained, and supervised and are available in sufficient numbers for the emergency services provided.

E. Unless otherwise provided for by the governing body, equipment, drugs, and other agents recommended by the *Emergency Care Guidelines* of the American College of Emergency Physicians are available.

F. Laboratory and radiology services described in Chapters 16 and 17 of this *Handbook* are immediately available.

G. Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, and hospitals as needed to assure high-quality patient care.

H. Adequate specialty consultation services are immediately available.

I. Health care practitioners who maintain skills in advanced cardiac and trauma life support are present in the facility at all times.

J. All emergency services personnel maintain skills in basic cardiac life support.

Note: *Organizations providing emergency services may obtain information on important areas of patient care from the American College of Emergency Physicians, 1125 Executive Circle, Irving, TX 75038. Telephone 214/550-0911. This information will assist organizations that are seeking accreditation for their emergency services to evaluate and improve the quality of care they provide.*

Immediate/Urgent Care Services

14

If an accreditable organization implies by its activities, advertising, or practice that it provides immediate and urgent care on a routine or regular basis, such care meets the needs of the patients and is provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. The range of services offered by the organization and its hours of operation are clearly defined and communicated to the public and relevant organizations.

B. Such organizations, unless they also provide emergency services, do not solicit patients with life-threatening conditions.

C. Patients seeking immediate/urgent care services are seen without prior appointments.

D. Immediate/urgent care services are performed only by health care practitioners who are licensed to perform such procedures within the state (province) in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical personnel and after medical review of the practitioner's documented education, training, experience, and current competence.

E. During hours of operation, at least one qualified physician is present or immediately available.

F. The organization is prepared in terms of personnel, equipment, and procedures to evaluate, stabilize, and transfer medical emergencies that may present themselves or arise in conjunction with services provided by the organization.

G. Equipment, drugs, and other agents necessary to provide immediate/urgent care services are available.

H. Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, and hospitals as needed to assure high-quality patient care.

I. Laboratory and radiology services described in Chapters 16 and 17 of this *Handbook* are available to meet the needs of patients receiving immediate/urgent care.

J. Arrangements have been made to assure that adequate specialty consultation services are available.

K. Health care practitioners who maintain skills in cardiac and trauma life support are present in the facility at all times.

Pharmaceutical Services

Pharmaceutical services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Pharmaceutical services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.

B. Pharmaceutical services are provided in accordance with ethical and professional practices and applicable federal and state (provincial) laws.

1. Staff demonstrate knowledge of applicable state (provincial) pharmaceutical laws.
2. Records and security are maintained to assure the control and safe dispensing of drugs in compliance with federal and state laws.

C. Pharmaceutical services provided by the organization are supervised by a licensed pharmacist or, when appropriate, by a physician or dentist who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.

D. A pharmacy owned or operated by the organization is supervised by a licensed pharmacist.

E. Pharmaceutical services made available by the organization through a contractual agreement are provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the organization.

F. Patients are not required to use a pharmacy owned or operated by the organization.

Pathology and Medical Laboratory Services

16

Pathology and medical laboratory services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.

B. Pathology and medical laboratory services include, but are not limited to,

1. conducting laboratory procedures that are appropriate to the needs of the patients
2. performing tests in a timely manner
3. distributing test results within 24 hours after completion of a test and maintaining a copy of the results in the laboratory
4. performing and documenting appropriate quality assurance procedures including, but not limited to, calibrating equipment periodically and validating test results through the use of standardized control specimens or laboratories.

C. Dated reports of all examinations performed are made a part of the patient's clinical record.

D. Pathology and medical laboratory services provided by the organization are directed by a pathologist or another physician who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.

E. Sufficient adequately trained and experienced personnel are available to supervise and conduct the work of the laboratory.

F. Established procedures are followed in obtaining, identifying, storing, and transporting specimens.

G. Complete descriptions are available of each test procedure performed by the laboratory, including sources of reagents, standards, and calibration procedures, and information concerning the basis for the listed "normal" ranges is also available.

H. Sufficient space, equipment, and supplies are provided to perform the volume of work with optimal accuracy, precision, efficiency, and safety.

Diagnostic and Therapeutic Imaging Services

Diagnostic and therapeutic imaging services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Diagnostic (and therapeutic) imaging services provided or made available are appropriate to the needs of the patients and adequately support the organization's capabilities.

B. Diagnostic imaging services include, but are not limited to,

1. providing radiographic, fluoroscopic, or other diagnostic (and therapeutic) imaging services that are appropriate to the organization's function
2. interpreting diagnostic images and other visual diagnostic documents and supplying reports in a timely manner
3. providing summaries of radiotherapy and other therapeutic procedures performed in a timely manner
4. maintaining duplicate reports of services and retaining diagnostic images in the Diagnostic Imaging Department for the time required by applicable laws and policies of the organization

C. A radiologist authenticates all examination reports, except reports of specific procedures that may be authenticated by specialist physicians or dentists who have been granted privileges by the governing body or its designee to authenticate such reports.

D. Authenticated, dated reports of all examinations performed are made a part of the patient's clinical record.

E. Diagnostic imaging services provided by the organization are directed by a physician or dentist who is qualified to assume professional, organizational, and administrative responsibility for the quality of the services rendered.

F. Sufficient adequately trained and experienced personnel are available to supervise and conduct the work of the diagnostic imaging service.

G. Policies address the quality aspects of the imaging services including, but not limited to,

1. performing imaging services only upon the order of a health care practitioner (such orders are accompanied by a concise statement of the reason for the examination)
2. limiting the use of radioactive or other potentially harmful material to physicians or dentists who have been granted privileges for such use on the basis of their education, training, experience, and current competence.

H. Policies address the safety aspects of the imaging services including, but not limited to,

1. regulation of the use, removal, handling, and storage of potentially hazardous materials
2. precautions against electrical, mechanical, magnetic, ultrasonic, radiation, and other potential hazards
3. proper shielding where radiation, magnetic field, and other potentially hazardous energy sources are used
4. acceptable monitoring devices for all personnel who might be exposed to radiation, magnetic fields, or otherwise harmful energy (such monitoring devices are to be worn by personnel in any area with a potentially hazardous energy field)
5. maintenance of invasive energy exposure records on personnel
6. instructions to personnel in safety precautions and in dealing with emergency hazardous energy field exposure

7. periodic evaluation by qualified personnel of energy sources and of all safety measures followed, including calibration of equipment, in compliance with federal, state (provincial), and local laws and regulations.

I. Adequate space, equipment, and supplies are provided to perform the volume of work with optimum accuracy, precision, efficiency, and safety.

d. A policy addresses the retention of image records.

K. Proper warning signs are in place, alerting the public and personnel to the presence of hazardous energy fields, emphasizing concern for particularly susceptible individuals, including

1. pregnant females
2. patients with pacemakers
3. patients with metal implantations, including surgical clips for cerebral and abdominal aneurysm repair
4. patients or personnel with magnetically enscribed credit cards
5. patients or personnel wearing metallic objects capable of potentially dangerous motion.

Occupational Health Services

If an accreditable organization provides occupational health services, such services are organized to assure a safe and healthy workplace for employees, meet the needs of the patients served, and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Occupational health services provided are in compliance with the relevant standards promulgated by local, state, provincial and/or federal law and regulations, including the Occupational Safety and Health Act and workers' compensation laws.

B. Occupational health services are provided by personnel who

1. are informed of the potential workplace hazards for each employee
2. have the necessary and appropriate training, credentials, and skills to carry out their responsibilities
3. have knowledge of the workplace hazards for each employee
4. have appropriate access to a physician with expertise and credentials in occupational health care
5. have access to and utilize, as appropriate, consultative services associated with evaluating workplace hazards such as industrial hygiene, ergonomics, toxicology, and epidemiology
6. have ready access to appropriate reference materials in occupational health care
7. participate in continuing medical education in occupational health.

C. The management of acute injury includes, in addition to the characteristics in chapters 13 and 14 of this *Handbook*, measures to minimize disability and return the employee to an optimal functional state as soon as possible. Consideration should be given to consultation with medical specialists, physiotherapists, and rehabilitation specialists where indicated.

D. Employee medical complaints are managed in the usual manner with consideration given to

1. the relationship to the workplace environment and work practices
2. fitness for continuing present work practices
3. any disability that may be sustained.

E. Evaluations of employees absent from work are provided to assure sufficient health to return to their particular workplace. Such evaluations include, but are not limited to,

1. the extent and duration of the condition that caused the absence from work
2. the extent and duration of potential hazards that may affect the employee's health.

F. Pre-placement examinations to include pre-employment examinations are provided that consider the health of the individual and the requirements of the prospective workplace.

1. Prospective job requirements are made known to the prospective employee and the examiner.
2. Capabilities or limitations of the prospective employee are reviewed.
3. The applicant is informed of the findings and the recommendations of the examination.
4. The employer is informed of the recommendations of the examination.

G. Medical surveillance evaluations of employees are conducted at appropriate intervals to identify as early as possible adverse effects from exposure to workplace hazards.

1. Employees are advised of all findings, their medical significance, and any relationship of these findings to their employment.
2. Employers are advised of any adverse health effects within an employee that might be attributed to the workplace. If adverse health effects are sufficient, removal of the employee from the hazard or attenuation of the hazard is advised.

H. Employee education and/or training are provided in the potential adverse health effects of workplace hazards and methods by which such exposure might be reduced.

I. Lifestyle habits (weight, diet, exercise, alcohol and/or tobacco use, etc.) are assessed when potential exposure to hazardous agents may be affected by those habits. When assessed, specific practices are advised that might improve health.

J. Personal information about an employee, that is unrelated to the ability to perform the specified job safely, is handled in a confidential manner and only disclosed to an employer if there is a need and permission of the employee is granted.

K. A system of records management is maintained that meets the requirements in Chapter 6 of this *Handbook* as well as the needs for reporting health surveillance data and other statutory requirements.

L. Where occupational health services are provided by a unit(s) within a larger organization, the sponsoring organization provides evidence of management's understanding and commitment to the services provided.

Other Professional and Technical Services

Professional and technical services provided or made available by an accreditable organization, even though they are not specifically mentioned in this *Handbook*, meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Such services may include, but are not limited to, various medical specialties, audiology, health education, nursing, nutrition, occupational therapy, optical services, physical therapy, psychology, social work, and speech therapy.

B. Such services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.

C. Such services are provided by personnel who have been selected in accordance with standard 2.H.

D. Such services are provided in accordance with ethical and professional practices and applicable federal and state (provincial) laws and regulations.

E. Such services will be evaluated by using applicable standards from other chapters of this *Handbook*.

Teaching and Publication Activities

20

If staff are involved in teaching or publishing, an accreditable organization has policies governing those activities that are consistent with its mission, goals, and objectives. Such an organization has the following characteristics.

A. Policies concerning teaching activities address:
1. the terms and conditions of reimbursement or other compensation;
2. the reasonableness of the time spent away from direct patient care and administrative activities;
3. the training of all students and postgraduate trainees, including the extent of their involvement in patient care activities.

B. The policy concerning the provision of health care by personnel in any student or postgraduate trainee status provides for close and adequate supervision and for informing the patient of the status of the provider.

C. Policies concerning publishing activities address:
1. the need for governing body approval when the views, policies, and procedures expressed in the publication are attributed to the organization;
2. the terms and conditions of compensation from publication and the cost of publication.

Research Activities

If research is conducted, an accreditable organization establishes and implements policies governing research that are consistent with its mission, goals, objectives, and clinical capabilities. Such an organization has the following characteristics.

A. Research activities are performed in accordance with ethical and professional practices and legal requirements, and these activities are periodically monitored. Such activities include, but are not limited to, clinical trials of drugs and other biologicals, devices, implants, or instruments that are classified as investigational or experimental, and techniques that are new, experimental, innovative, or otherwise not yet accepted as standard medical or dental practice.

B. The protocols for conducting research are approved by the governing body or its designee after medical (or dental) and legal review.

C. Any research activities carried out within the organization are appropriate to the expertise of staff and the resources in the organization.

D. Individuals engaged in research are provided with adequate facilities.

E. Provisions are made to assure that the rights and welfare of all research subjects are adequately protected and that the informed consent of the subject, in the language spoken by him or her, is obtained by adequate and appropriate methods.

F. All professional staff are informed of the organization's research policies.

Revisions to Standards Since the 1987-88 Edition

Appendix A

This appendix describes changes that have been made to AAAHC's accreditation standards since the publication of the 1987-88 edition of the *Accreditation Handbook for Ambulatory Health Care*. Changes affecting accreditation policies and procedures are incorporated into their appropriate sections and are not described here.

Two entirely new chapters have been added to the 1989-90 edition: Overnight Care and Services (Chapter 11) and Dental Services (Chapter 12). Anesthesia Services (Chapter 9) and Surgical Services (Chapter 10) now stand alone as separate chapters. In the previous edition, standards relating to these aspects of ambulatory care were contained in a single chapter titled Anesthesia and Surgical Services.

In addition to the new chapter on dental services, other language in the *Handbook* has been changed to reflect the inclusion of dentists and dental services in the scope of AAAHC's accreditation standards. Such changes will be found in the following chapters: Rights of Patients, Governance, Quality Assurance Program, Anesthesia Services, Pharmaceutical Services, and Diagnostic and Therapeutic Imaging Services.

In addition, the standards are augmented by three new appendices: Risk Management (Appendix D), Quality Assurance Program Analysis (Appendix E), and Clinical Record Worksheet (Appendix F).

Changes to specific standard sections are described below.

Governance

2.B.15 New language in the standard changes "developing a policy" to "developing a program" as one of the enumerated governing body responsibilities. Additionally, the elements of such a program are now fully specified in Appendix D of the *Handbook*, which is new to this edition.

2.G This new section of Chapter 2 details peer review requirements for organizations providing only dental services. (The former section 2.G now appears as 2.H).

Quality of Care Provided

4.D.1 The word "medical" has been deleted from the previous phrase "diagnosis and treatment of their *medical* condition."

Quality Assurance Program

5.I.1.L. "Over utilization and under utilization" have been added to this listing of sources of identifiable problems.

Clinical Records

Previously titled "Medical Records." All former references to "medical records" in this chapter and the remainder of the *Handbook* have been changed to either "clinical records" or simply "records." Please refer to the note at the end of the chapter for an explanation of the rationale for this change.

Facilities and Environment

8.A.3 Compliance with applicable federal regulations has been added to this listing. Note that the insertion of this item affects the numbering scheme of the other items following it on the list.

8.R and 8.S Both sections now specify the 1985 edition of the *Life Safety Code®* rather than the 1981 edition.

A note added to the end of the standard clarifies the use of the various editions of the *Life Safety Code®*.

Anesthesia Services

Anesthesia Services now stands alone in this edition as a separate standard. In the previous edition it was combined with the surgical services standard. A new subsection (9.F) has been added and certain other subsections ordered as follows: the former 9.E is now 9.F; 9.G is now 9.H; 9.I is 9.J; 9.J is 9.K. A note has also been added at the end of the chapter clarifying the applicability of this standard to surveyed organizations.

Surgical Services
Surgical Services now stands alone in this edition as a separate standard. In the previous edition it was combined with the anesthesia standard. The sections numbered 9.K through 9.CC in the previous edition are now designated 10.A through 10.S. Otherwise there are no additions to or changes in the standard relating to surgical services.

Overnight Care and Services
This standard is new to the 1989-90 edition and should be reviewed carefully in its entirety.

Dental Services
This standard is new to the 1989-90 edition and should be reviewed carefully in its entirety.

Diagnostic and Therapeutic Imaging Services
17.G.2 Education has been added to the list describing the basis of granting privileges.

Occupational Health Services
Extensive revisions and additions have been made throughout this chapter in the 1989-90 edition. Readers are advised to review it carefully in its entirety.

Appeal of Accreditation Decision

Appendix B

Appeal of Accreditation Decision

Any decision by the Accreditation Committee is promptly reported to the head of the organization's governing body, the chief medical executive, and the administrative head of the organization. Such notice includes an explicit statement of the reasons for the decision. Any decision to deny, revoke, or defer accreditation, or to grant a one-year term of accreditation will be accompanied by an explanation that the organization is entitled to an interview with a representative of the AAAHC to exchange information and to further clarify the findings and the decision. If the organization fails to request such an interview within 20 days of the notification, the decision becomes final.

The interview requested by the organization is ordinarily held within 30 days following receipt of its written request. At least 20 days before the interview, the organization is notified of the time and place of the interview and is provided with a copy of the survey report and any supplemental information that is not already in the organization's possession and that affected the accreditation decision. This interview will usually be held at the AAAHC office.

If, on the basis of this interview, the Executive Director of the AAAHC concludes that the decision of the Accreditation Committee should be reconsidered, the matter is referred to the Accreditation Committee for reconsideration. Such reconsideration ordinarily occurs within 30 days following referral. A decision of the Accreditation Committee, upon such reconsideration, to accredit the organization is final.

Appeals Hearing Panel

If, on the basis of this interview, the Executive Director of the AAAHC concludes that the decision of the Accreditation Committee should not be altered, or, if following reconsideration, the Accreditation Committee does not alter its decision, the organization may request a hearing before an Appeals Hearing Panel composed of impartial individuals, other than members of the Board of Directors of AAAHC, designated by the Executive Director of AAAHC. The organization is notified promptly of the action of the AAAHC or the Accreditation Committee, the reasons for the action, and the right of the organization to a hearing. If the organization's written request for such a hearing is not received within 20 days following the mailing of such notification, the decision of the Accreditation Committee to deny or revoke accreditation becomes final.

The hearing requested by the organization is ordinarily held within 45 days following receipt of its written request. At least 35 days before the hearing, the organization is notified of the time and place of the hearing and is provided with a copy of the survey report and the supplemental information that is not already in its possession and that affected the accreditation decision. The Appeals Hearing Panel will usually be held at the AAAHC office. At any hearing before the Appeals Hearing Panel, the organization may be accompanied by counsel, make oral presentations, offer testimony, and interview any available surveyor(s) who participated in the survey. At least 25 days before any such hearing, the organization may request in writing the presence of any such surveyor(s) it wishes to interview. Subsequent to the organization's request for a hearing, members of the Accreditation Committee will not participate in any discussion or vote by the Board of Directors relative to the accreditation of the organization.

Decision Following An Appeals Hearing

Following the hearing, the Appeals Hearing Panel will promptly submit an accreditation recommendation to the Board of Directors. A decision by the Board of Directors to accredit the organization is final. If, however, the Appeals Hearing Panel recommends not accreditation or revocation of accreditation, or if the Board of Directors questions the Panel's recommendation to accredit, the organization may appeal directly to the Board.

The organization is notified promptly of the action of the Panel or the Board, the reasons for the action, and the right of the organization to appeal to the Board. The organization's written request for appeal must be received within 20 days following the mailing of such notification. The Board of Directors will consider any such appeal at the first regular meeting it holds at least 30 days after receipt of the request for appeal. The organization may submit, at least 20 days prior to such a meeting, written responses or comments for review by the Board. The Board will review any such written responses and comments submitted, the survey report, and any other material considered by the Appeals Hearing Panel, and make an accreditation decision that will be final.

When an organization appeals an accreditation decision, the previous accreditation status of the organization is retained until a final accreditation decision is made.

Reasonableness of Standards

Whenever the decision to deny or revoke accreditation is based upon noncompliance with any standard or standards whose reasonableness is challenged by the organization, the organization has the right to request a hearing before the Standards and Survey Procedures Committee of the AAAHC. A written request for such a hearing must be received by the AAAHC within 20 days following the mailing of notification to the organization of the accreditation decision, and the hearing is ordinarily held within 45 days of receipt of the request.

The right of the organization to be accompanied by counsel, to submit written comments, to make oral presentations, and to offer testimony is the same as provided for hearing before the Appeals Hearing Panel. Any other party who, in the judgment of the Standards and Survey Procedures Committee, may be significantly and adversely affected by an accreditation decision of the AAAHC involving the reasonableness of any standard is entitled, upon written request, to participate in any hearing before the Standards and Survey Procedures Committee, and any such party is given written notice of any such hearing and of the party's rights in connection therewith at least 20 days prior to the date of the hearing.

The Standards and Survey Procedures Committee considers all information provided by the AAAHC, the organization, and any other interested parties and reports to the Board of Directors its judgment as to the reasonableness of the standard(s) challenged by the organization. The Standards and Survey Procedures Committee also may recommend any amendments for consideration and action by the Board of Directors at its next meeting. If the Board of Directors amends any challenged standard, the organization is entitled to a resurvey to determine compliance with the amended standard. Whenever such resurvey is necessary in the judgment of the AAAHC, it is conducted promptly at the expense of the AAAHC.

Under extraordinary circumstances and with the mutual consent of the organization and the AAAHC, the number of days following receipt of the organization's request for interview or hearing within which such interview or hearing must be held may be increased.

Supplemental Checklist for Ambulatory Surgery

Appendix C

Instructions

This checklist enables organizations seeking accreditation and AAAHC surveyors to determine compliance with AAAHC Standards 8R and 8S (Facilities and Environment). These standards require compliance with the NFPA 101® *Life Safety Code.*®

All organizations providing ambulatory surgery (ambulatory surgery centers, surgery units in group practices, office surgery facilities, and so forth) shall complete this supplemental checklist and have it available for the AAAHC surveyor prior to the on-site survey. The organization should have its own architect or engineer certify compliance with the relevant code and have such documentation available at the time for the on-site survey. If the organization is in the process of building or renovating its facilities, this checklist should be used to assess compliance with the NFPA code and AAAHC standards.

If the authority having jurisdiction has permitted an exception or waiver to any of these items, a signed statement from the authority regarding such waiver or exception should be available to the AAAHC surveyor.

Organizations that are certified by Medicare must provide copies of the inspection report to AAAHC surveyors at the start of the on-site survey.

This checklist must be completed prior to survey. It will also be reviewed by the AAAHC surveyor during the on-site survey and submitted as part of the survey report.

All citations such as (Section 5-8) are references to specific sections of the 1981 *Life Safety Code*® unless otherwise noted.

Life Safety Code® and 101® are registered trademarks of the National Fire Protection Association (NFPA), Quincy, Massachusetts.

	Yes	No	Uns	N/A
1. Facility is in a one-story building.				
2. Buildings two or more stories in height of TYPE II-000, TYPE III-200, or TYPE V-000 are equipped throughout with an approved automatic sprinkler system.				
3. Building is of construction type ______.				
4. At least two exits, remote from each other, are provided for each floor or fire section of the building.				
5. Rooms or suites of rooms of more than 1,000 square feet have at least two exit access doors remote from each other.				
6. Dead-end corridors do not exceed 50 feet.				
7. Travel distance between any room door required for exit access and an exit does not exceed 100 feet. The travel distance between any point in a room and an exit does not exceed 150 feet.				
8. At least half of the required exit capacity from upper floors discharges directly to the exterior of the building.				
9. Designated aisles, corridors, passageways, and exit ways are illuminated as follows: "All exit access areas including designated stairs, aisles, corridors, ramps, and passages are illuminated to a minimum value of 1 footcandle measured at the floor. Lighting fixtures are so arranged that the failure of any single light source (i.e., an electric bulb) will not leave any exit access areas in darkness. All exit access areas are illuminated at all times of possible use from any occupied area. No battery-operated electric light is used for non-emergency illumination of exit access areas." (Section 5-8)				
10. Emergency illumination is provided as follows: "There is no appreciable interruption of illumination during change for any cause from regular emergency power and back again. When emergency lighting is powered by a prime mover-operated electric generator, the interruption in power/lighting is no more than 10 seconds. Emergency lighting levels are maintained as specified for non-emergency lighting (see No. 9 above) for a period of not less than 1½ hours in the event of failure of normal light. The switch to emergency lighting is automatic and repeatable without manual intervention. Battery-operated emergency lights shall use only rechargeable batteries with equipment for maintaining them in properly charged condition." (Section 5-9)				
11. Exits and exit access ways are marked as follows: "Exits, and all access ways to exits not immediately obvious to occupants, are marked by readily visible signs. Signs are placed so that no point in exit access is more than 100 feet from the nearest visible sign. Every exit sign shall be well illuminated, either externally or internally, with translucent letters by emergency lighting facilities." (Section 5-10)				

	Yes	No	Unk	N/A
12. Doors of patient treatment, diagnostic, or recovery rooms are arranged to permit exit from the room by a simple operation without the use of a key.				
13. Exit and exit access doors are at least 34 inches wide.				
14. Corridors for exit access are at least 44 inches wide.				
15. Where general anesthesia or life support equipment is used, an emergency power system is provided as follows: "(A generator system is not required where battery-operated equipment is provided.) Where general anesthesia (including nitrous oxide) or life support equipment is used, an emergency power system is provided. The emergency power system may consist of a generator, a battery system, or self-contained batteries integral with equipment. Components of the emergency electrical system and components of the normal system are located (physically separated) to minimize interruption or simultaneous failure due to local disturbances. The emergency system is capable of supplying power for all functions and equipment served of duration adequate for life safety and orderly cessation of procedures (1½ hour minimum). Where generators are used for emergency power, fuel is stored on-site." (NFPA 76A)				
16. Vertical openings such as stairways, elevator shaftways, escalators, and building service shaftways are enclosed as follows: "Vertical openings such as required exit stairways, escalators, and elevator shaftways are enclosed from floor to rated ceiling (or structure above) with construction of one-hour fire resistance when connecting three stories or less. Vertical openings connecting more than three stories are two-hour fire resistive construction. An open atrium, if provided, has no horizontal dimension less than 20 feet and a minimum opening of 1,000 square feet. Buildings that contain atriums are protected throughout by an automatic sprinkler system and an automatic ventilation system for exhaust of atrium-space smoke or pollutants." (Section 6-2)				
17. Any door with a required fire protection rating, such as stairways, exit passageways, horizontal exits, smoke barriers, or hazardous area enclosures, if held open, will close automatically by the activation of the manual fire alarm system and either smoke detectors arranged to detect smoke on either side of the opening or a complete automatic sprinkler system.				
18. Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected as follows: "Laboratories are separated from surrounding health care areas and from exit corridors by one-hour fire resistive construction. Laboratories employing severe quantities of flammable, combustible, or hazardous materials are separated from surrounding areas by at least 2-hour fire resistive construction or are protected throughout by an approved automatic sprinkler system. Where provided, the automatic sprinkler system shall include fire extinguishment and fire detection systems connected to and immediately activated to the facility fire alarm system. Where any person may be exposed to				

	Yes	No	Unk	N/A
injurious or corrosive materials, an emergency shower for the flushing of eyes and body is provided (NFPA 56FC). Gas containers for laboratory use are stored in a separate room or enclosure reserved exclusively for that use. Such storage area(s) is/are vented and protected from surrounding areas by at least 2-hour fire resistive construction. Storage areas for oxidizing gases are separated from flammable gas storage by at least one-hour fire resistive construction.				
19. Anesthetizing locations are protected as follows: Inhalation anesthetics in free-standing ambulatory care facilities are nonflammable and administered in accordance with standards of NFPA 56G (NFPA 99, Chapter 3). Where anesthesia gases are provided from a central supply system, such system adheres to No. 20 listed below.				
20. Locations for the supply systems and storage of medical gases are protected in an approved manner. (See references following the checklist.)				
21. General storage, boiler or furnace rooms, fuel storage rooms, janitor closets, and maintenance shops are separated from other parts of the building by fire barriers having at least a one-hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems.				
22. Interior finish on walls and ceilings of exits, enclosed corridors, and exit access or discharge has a maximum flamespread rating of 75. (Note: A maximum flamespread rating of 200 is permitted in rooms. There is no requirement for flamespread on floor covering.) Interior finish on walls and ceilings of required exits and of enclosed corridors furnishing access to or from such exits shall be class A or B as defined in NFPA 101 (maximum flamespread rating of 75, maximum smoke development rating of 450). In areas not related to exiting or exit flow, interior finish materials shall be Class A, B, or C as defined in NFPA 101 (maximum smoke development rating of 450).				
23. A manual fire alarm system not of a pre-signal type is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department.				
24. Corridors used as exit access are separated from use areas by partitions with a fire resistance rating of at least one hour. Doors have at least a 20-minute fire protection rating and are equipped with a positive latch and closing device. Vision panels, if provided, in partitions or doors therein are fixed wired glass limited to 1,296 square inches per panel. (Indicate N/A for existing occupancies, open floor areas with available exits, corridors in a space occupied by a single tenant, and buildings provided with complete automatic sprinkler systems.)				

	Yes	No	Uns	N/A
25. Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a one-hour fire resistance rating. Doors in such barriers have at least a 20-minute fire protection rating and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors therein, are fixed wired glass limited to 1,296 square inches per panel.				
26. Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least a one-hour fire resistance rating. Doors in smoke barriers have at least 20-minute fire protection rating and are equipped with closing devices (latch not required). Vision panels are provided and are of fixed wire glass limited to 1,296 square inches per panel. (Indicate N/A for facilities of less than 2,000 square feet with an automatic smoke detection system.)				
27. Portable fire extinguishers are provided.				
28. Buildings over 75 feet in height housing ambulatory health care facilities are provided with a complete automatic sprinkler system.				
29. Utilities are installed in accordance with Section 7-1. Equipment utilizing gas and related gas piping shall be designed and installed in accordance with the National Fuel Gas Code, NFPA 54, or the Standard for Storage and Handling of Liquefied Petroleum Gases, NFPA 58. Electrical wiring and equipment shall be designed and installed in accordance with the National Electrical Code, NFPA 70.				
30. Heating, ventilating, and air conditioning are installed in accordance with the manufacturer's specifications and as follows: "Heating, ventilating, and air-conditioning ductwork and related equipment shall be designed and installed in accordance with the Standard for the Installation of Air Conditioning and Ventilating Systems, NFPA 90A, or Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, NFPA 90B, as applicable. Ventilating or heat-producing equipment shall be designed and installed in accordance with: Standard for the Installation of Blower and Exhaust Systems, NFPA 91; Standard for Chimneys, Fireplaces, and Vents, NFPA 211; Standard for Oil Burning Equipment, NFPA 31; National Fuel Gas Code, NFPA 54; National Electrical Code, NFPA 70, as applicable." (Section 7-2)				
31. Portable space-heating devices are not used.				
32. Elevators, dumbwaiters, and vertical conveyors are installed in accordance with Section 7-4. Elevators shall provide for fire fighter override provisions including emergency recall to the ground floor and manual override controls for emergency use. Vertical conveyors, including dumbwaiters, and pneumatic conveyors shall be protected as specified in No. 16. Service opening shall not be open to a required exit or element thereof. Where service openings may be open on more than one story at a time, there shall be provided closing devices, activated by smoke detectors				

	Yes	No	Uns	N/A
both inside and outside of the shaft, that automatically close all service doors upon detection of fire.				
33. Rubbish chutes, incinerators, and laundry chutes are installed as follows: "Rubbish chutes, incinerators, and laundry chutes shall be installed and maintained in accordance with the Standards on Incinerators, Waste and Linen Handling Systems and Equipment, NFPA 82. Each rubbish chute shall be protected as a vertical opening as specified in No. 16. Inlet openings serving chutes shall be protected as doorways in the required fire resistive shaft. Such chute inlets or doors shall open only to a separate room designated exclusively for that purpose. The room shall be separated from other spaces by a fire resistive rating of not less than one hour, or an approved automatic extinguishing system. If rubbish includes materials which are liable to burn with extreme rapidity or from which poisonous fumes or explosions are possible in the event of fire, then both one-hour fire resistive construction and automatic sprinkler system are required." (Section 7-5)				
34. There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. A simple floor plan, showing the evacuation routes, is posted in prominent locations on all floors.				
35. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.				
36. Smoking regulations are adopted to control smoking, and include the posting of "NO SMOKING" signs in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen are used or stored, and in any other hazardous location.				
37. No furnishings, decorations, or other objects are placed as to obstruct exits or visibility of exits.				
38. No furnishings or decorations of an explosive or highly flammable character are used.				
39. All combustible curtains including cubicle curtains are rendered and maintained flame-retardant.				

Risk Management

Appendix D

A risk management program is designed to protect the life and welfare of an organization's patients and employees. The risk management program has at least the following characteristics:

A. There is a person or committee responsible for the risk management program.

B. Policies and procedures of the risk management program address, but are not limited to:

- ☐ 1. consistent application of the risk management program throughout the organization, including all departments and all service locations.
- ☐ 2. methods by which a patient may be dismissed from care or refused care
- ☐ 3. methods for the primary provider (physician, podiatrist, or dentist) to review a patient's bill before it can be referred to a collection agency
- ☐ 4. reporting and reviewing all incidents reported by employees, visitors, or patients
- ☐ 5. periodic review of all litigation involving the organization and its staff and health care practitioners
- ☐ 6. review of all deaths, trauma, or adverse reactions occurring on premises
- ☐ 7. review of patient complaints
- ☐ 8. communications with the professional liability insurance carrier
- ☐ 9. methods of dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, reporters, and other media
- ☐ 10. methods of addressing the relationships with competing health care organizations.

C. The risk management program (either directly or through the quality assurance program) conducts a periodic review of clinical records and clinical record policies to assure that:

- ☐ 1. records are retained in accordance with state (provincial) statutes
- ☐ 2. objectivity is maintained in the recording of observations, and inappropriate remarks are not recorded
- ☐ 3. records are released only with the appropriate written authorization of the responsible physician or dentist
- ☐ 4. records are legible and signed by the responsible practitioner
- ☐ 5. records are complete and maintained according to the standards in Chapter 6, Clinical Records, in the *Handbook*.

D. Systems are in place to:

- ☐ 1. monitor physician or dentist review of all laboratory and radiology reports prior to inclusion in the clinical record
- ☐ 2. notify patients of abnormal findings
- ☐ 3. document physician or dentist coverage after normal working hours, during holidays, and vacations
- ☐ 4. delineate the scope of practice of health care practitioners such as nurse practitioners, dental hygienists, and physician assistants.

E. Education in risk management activities is provided to all staff within the organization and includes, but is not limited to:

- ☐ 1. the dissemination of newsletters and other relevant material provided by the organization's liability insurance carriers
- ☐ 2. in-service educational programs
- ☐ 3. external seminars on risk management.

F. Policies and procedures are present to:

- ☐ 1. prevent a physician or dentist from pre-signing prescription blanks
- ☐ 2. prevent prescribing by non-physicians or dentists, unless authorized by state (provincial) law
- ☐ 3. prevent unauthorized prescription refills
- ☐ 4. control inventory

Quality Assurance Program Analysis

Appendix E

		Yes	No	N/A
1. Is there an organized quality assurance program?	1.			
2. When did the governing body formally adopt the written quality assurance program? ______ (month/yr.)				
3. Who is responsible for the quality assurance program? ______				
4. How often are quality assurance reports given to the governing body? ______				
5. Does the quality assurance program's structure provide for ultimate accountability to the governing body?	5.			
6. Is there adequate staff to support the quality assurance program?	6.			
7. Are clinical concerns addressed?	7.			
8. Are administrative concerns addressed?	8.			
9. Are cost-of-care issues addressed?	9.			
10. Are actual or potential problems affecting patient outcomes (results of care) addressed?	10.			
11. Is there ongoing monitoring of important aspects of care?	11.			
12. Are incident reports related to individual medical care reviewed as part of the quality assurance program?	12.			
13. Are individual cases reviewed?	13.			
14. Are at least two physicians or dentists involved in quality assurance activities?	14.			
15. Does the review process include physician or dentist review of clinical records?	15.			
16. Is the Medical Director or a Medical Review Committee ultimately responsible for medical decisions?	16.			

		Yes	No	N/A
17. Are the physicians involved in the quality assurance program on the staff of the organizations?	17.			
18. Are the physicians involved in the quality assurance program under contract as providers of care to the organization?	18.			
19. Does the review cover all patient care settings, including:				
a. hospital inpatient?	19a.			
b. post-hospital (i.e., nursing home)?	19b.			
c. ambulatory?	19c.			
d. other technical services (e.g., mental health, dental, etc.)?	19d.			
20. For single service organizations such as surgery centers, indicate which patient care settings are reviewed.				
21. Are decisions made on:				
a. quality of care?	21a.			
b. appropriateness of care?	21b.			
c. access to care?	21c.			
d. availability of care?	21d.			
22. Do health care practitioners participate in the development and application of criteria used to evaluate the care they provide?	22.			
23. Has the quality assurance program identified and applied uniform appropriate quality standards for all providers?	23.			
24. Has the quality assurance program addressed under-utilization of services?	24.			
25. Has the quality assurance program addressed over-utilization of services?	25.			
26. Has the quality assurance program addressed the necessity for surgery performed?	26.			
27. Are reasonable sampling methods used to select cases for review?	27.			
a. Is random sampling done?	27a.			
b. Is problem-oriented sampling done?	27b.			
28. Is there sufficient individual medical or dental care review to document problems regarding quality of care?	28.			

		Yes	No	N/A
29. Is the collected data periodically evaluated to identify unacceptable or unexpected trends or outcomes?	29.			
30. Is there evidence that corrective actions have resulted from negative findings of the quality assurance program?	30.			
31. Are quality assurance findings incorporated into educational activities?	31.			
32. Are appropriate records maintained for quality assurance activities?	32.			
33. Are appropriate minutes of quality assurance meetings maintained?	33.			
34. Has the organization's quality assurance plan been in operation for a sufficient period of time to demonstrate actual performance?	34.			
35. Does the quality assurance program handle complaints or grievances?	35.			
a. If not, who is responsible for their disposition? ______				
b. Is the resolution of all patient complaints or grievances well documented?	35b.			
36. Is the quality assurance program responsible for utilization review?	36.			
a. If not, who is responsible for this? ______				
b. Are issues from the utilization review program that affect quality of care referred to the quality assurance program?	36b.			
37. Are patient education and information materials available and accurate?	37.			

Quality Assurance Study Analysis

Instructions

These six questions should be answered for each quality assurance study completed by the organization. This information may be maintained in a set of QA Committee minutes, or in a narrative or summary form for each topic studied. These elements are essential, however, for all quality assurance activities. For further information, please contact the AAAHC office.

1. What important problem or concern in the care of patients was identified?

2. How were the frequency, severity, and source of suspected problems or concerns evaluated?

3. What corrective measures were implemented to resolve the problem?

4. How was the problem re-evaluated to determine whether corrective measures were successful?

5. If the problem remained after the initial corrective measures, what alternate measures were taken to resolve the problem?

6. How were the results reported to appropriate personnel, the chief executive officer, and the governing body?

AAAHC Clinical Record Worksheet

Organization

Location

Date

Appendix F

Instructions:
Check each box as:
Adequate +
Inadequate –
Not Applicable n.a.
Write all comments on back of record.

	Chart Number									
The record is legible to clinical personnel with or without assistance.										
The history and physical are adequate based on the chief complaint and other entries in the chart.										
The diagnoses are appropriate for the findings in the history and physical.										
The diagnostic procedures are appropriate based on the diagnosis.										
Treatment is consistent with the working diagnosis.										
Consultation and referrals are appropriate and timely.										
Appropriate follow-up is provided.										
When indicated, diagnostic summaries are present and used appropriately.										
Allergies and drug sensitivities are clearly and consistently recorded in a prominent place.										
Laboratory reports, radiology reports, and other pertinent information are recorded adequately.										
Significant advice given by telephone is recorded.										
When indicated, operative reports are present and adequate for the procedure.										
The operative record includes adequate lab work, pt. conditions in Surgery and RR, consent form, and post-operative instructions.										
Anesthesia records, when indicated, are present and include assessment pre- and post-operatively.										
For dental services, the clinical record includes a comprehensive medical history that is periodically updated.										
Additional comments. (*If checked, write on back of sheet with chart number.*)										

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History of the Accreditation Association for Ambulatory Health Care, Inc.

Appendix G

A Solid Foundation

A sense of obligation coupled with a willingness to critically evaluate one's own performance is a time-honored tradition of the medical profession. This same tradition is the foundation on which the Accreditation Association for Ambulatory Health Care, Inc., is built. From this solid base, the Accreditation Association has grown strong and successful through the cooperation, mutual respect, and professional pride of its leaders and the physicians, administrators, and other ambulatory health care professionals who have contributed to its efforts and participated in its program.

The AAAHC was incorporated in 1979, but its history spans nearly 20 years of independent and cooperative efforts by many national organizations all dedicated to high-quality ambulatory health care. This is the story of how those efforts culminated in the formation of the AAAHC and its accreditation program.

American Group Practice Association Concern for Quality

As early as the mid-1960s, the American Group Practice Association (then the American Association of Medical Clinics) began discussing the possibility of establishing a national accreditation program for medical group practices to assure the provision of high-quality care. AGPA bylaws, in fact, specified that the organization "periodically evaluate the conduct, performance, and quality of medical practice of member clinics in order to certify and accredit them as qualified, comprehensive medical and diagnostic centers."

After considerable study and deliberation, the AGPA Board of Trustees formed its Commission on Accreditation and charged it to develop an accreditation program under AGPA's auspices. In 1968 the Commission began to develop not only standards, but also a method to apply the standards to evaluate the quality of care delivered in ambulatory health care settings.

Because the medical record is the physician's primary tool for documenting treatment and communicating with other practitioners, AGPA focused on it as a way to evaluate ambulatory health care delivery. This was consistent with the Joint Commission on Accreditation of Hospitals, now the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which has always emphasized the importance of the medical record in its hospital accreditation programs.

The AGPA also spelled out other essential organizational aspects to be reviewed: the logical process of clinical care, educational activities, research by practitioners, technological support, qualifications and functions of staff physicians, organizational effectiveness, ethical considerations, and the environment. Other considerations included the size and scope of the practice and its orientation, philosophy, and geographic location. To allow the program to grow with the profession, flexibility was key in the standards and their application.

The AGPA Commission conducted its first on-site visits in 1969 and by September had completed 12 surveys of clinics ranging in size from seven to seventy physicians. At its annual meeting that year, AGPA awarded its first certificate of accreditation.

During the years that AGPA conducted its accreditation program, the Medical Group Management Association (MGMA) provided health care administrators to participate in the survey process. By the 1976 annual meeting, AGPA had conducted a total of 182 initial surveys and had scheduled 47 additional resurveys, evidence of the growing interest in accreditation.

Change and Cooperative Efforts

A number of interrelated factors influenced the next phase in the development of ambulatory health care accreditation. In the late 1960s and early 1970s, the focus of the health care delivery system began to change, shifting from the hospital to other health care delivery settings. Grants from the federal government spurred this change by funding new centers for primary care. These centers and the burgeoning number of neighborhood health centers and surgical centers found themselves ineligible to participate in any existing, formally organized quality assessment program.

In response to demand for such a program, the Joint Commission and the National Association of Neighborhood Health Centers (now the National Association of Community Health Centers) began to develop standards and survey procedures for these new types of ambulatory health care organizations. At about this same time, the AGPA opened its accreditation program to non-members and began to explore the feasibility of forming an accreditation program for ambulatory health care within the Joint Commission's structure.

In early 1974 the Joint Commission, in response to AGPA's interest, approved the formation of the Accreditation Council for Ambulatory Health Care. The Council was formally organized in May 1975 with its founding members representing the American Group Practice Association, American Hospital Association, American Medical Association, Group Health Association of America, and the Medical Group Management Association. Financial support for the Council's development was secured from the W.K. Kellogg and the Robert Wood Johnson Foundations.

Other Voices and New Horizons

College Health

The American College Health Association (ACHA) began to consider a quality assessment program for its member health centers at about the same time that AGPA began developing its accreditation program in the mid-1960s. Because health centers on college campuses were frequently responsible for occupational and environmental health, sanitation, health education, and other activities besides direct patient care services, the ACHA's standards focused on the health service and its relationship to the entire institution. And, for the first time, mental health services received considerable attention in standards for ambulatory health care organizations.

ACHA conducted a pilot survey in 1967. The pilot was successful and ACHA launched its certification program. Over the next thirteen years, more than 80 college and university health centers were surveyed.

Ambulatory Surgery

In 1974, because ambulatory surgical facilities were not eligible for survey by JCAH, the Society for the Advancement of Freestanding Ambulatory Surgical Care (now the Federated Ambulatory Surgery Association) identified the need to develop voluntary standards for its members.

Although many of the existing ambulatory health care standards were applicable to surgery centers, additional standards were needed for surgical and nursing care, the administration of anesthesia, and the environment of the operating room. FASA was also interested in developing standards for the cost of care and the use of alternative resources.

In 1975, FASA began to develop an accreditation program for ambulatory surgery centers. In the first year of operation, FASA surveyed ten organizations.

Renewed Commitment

In October 1978, when the Joint Commission decided to dissolve its accreditation councils and to replace them with professional and technical advisory committees, representatives from the member organizations of the Accreditation Council for Ambulatory Health Care urged JCAH to modify its plans. They suggested several alternatives that would keep the ambulatory accreditation program intact, alternatives that were consistent with most aspects of the JCAH's reorganization plan. The JCAH, however, reaffirmed its decision to reorganize.

Most of the member organizations of the Accreditation Council for Ambulatory Health Care were unable to accept the loss of responsibility and authority that their original agreement with JCAH had assured. The feeling of ownership of the program was especially strong because of the previously existing programs and the expertise these member organizations had brought to the Accreditation Council. Thus, they withdrew from JCAH.

The American College Health Association, which had begun discussions with JCAH about cooperative accreditation efforts, suspended its discussions when JCAH reorganized. Likewise, the Freestanding Ambulatory Surgical Association suspended its pursuit of cooperative efforts with JCAH.

AAAHC Is Founded

The Accreditation Association for Ambulatory Health Care, Inc., was incorporated in Illinois as a not-for-profit corporation on March 22, 1979. Its purposes, as stated in its certificate of incorporation, are to organize and operate a peer-based assessment, education, and accreditation program for ambulatory health care organizations as a means of assisting them to provide the highest achievable level of care for recipients in the most efficient and economically sound manner.

Specifically the corporation is organized

a. to conduct a survey and accreditation program that will promote and identify high-quality, cost-effective ambulatory health care programs and services

b. to establish standards for accreditation of ambulatory health care organizations and services

c. to recognize compliance with standards by issuance of certificates of accreditation

d. to conduct programs of education and research that will further the other purposes of the corporation, to publish the results therof, and to accept grants, gifts, bequests, and devices in support of the purposes of the corporation

e. to provide programs that will facilitate communication, sharing of expertise, and consultation among ambulatory health care organizations and services

f. to assume such other responsibilities and conduct such other activities as are compatible with such survey, standard setting, accreditation, and communication programs.

The six charter members of the corporation were the American College Health Association, the American Group Practice Association, the Freestanding Ambulatory Surgical Association, the Group Health Association of America, the Medical Group Management Association, and the National Association of Community Health Centers. Each of the organizations designated AAAHC as its national accrediting body, appointed members to the Board of Directors, and contributed funds to the development and operation of the program.

Since AAAHC's founding, both the American College Health Association and the Freestanding Ambulatory Surgical Association have discontinued their own accreditation programs in order to fully support the AAAHC program. In 1981, the Group Health Association of America withdrew its membership in AAAHC to sponsor a review of federally qualified HMOs. GHAA, however, remains fully supportive of AAAHC and the principles of voluntary accreditation.

Responsiveness to a Changing Profession

True to its basic purpose, AAAHC continues to expand its horizons to meet the changing needs of ambulatory health care organizations. In 1982, the Board of AAAHC approved the addition of a new member organization, the Outpatient Ophthalmic Surgery Society.

In 1983, the American Academy of Facial Plastic and Reconstructive Surgery, the National Association of Freestanding Emergency Centers (now the National Association for Ambulatory Care), and the Society for Office-Based Surgery (now the American Society of Outpatient Surgeons) were accepted for membership on the AAAHC Board of Directors.

In 1987, the American Occupational Medical Association (now the American College of Occupational Medicine) joined AAAHC. Standards were developed for occupational health services, and AAAHC began the survey and accreditation of industry-based occupational health services. These new standards were also applied to all other organizations that provide occupational health services.

Also in 1987, the American Academy of Dental Group Practice voted to discontinue its own accreditation program for dental group practices and became a member of AAAHC. The 1989-90 edition of the *Handbook* now contains specific standards for dental practices, and the survey and accreditation of dental groups has begun.

In 1989, the National Association for Ambulatory Care withdrew its membership, but remains supportive of accreditation for its members.

AAAHC continues to review its standards and survey procedures to ensure their relevance to the ever-changing health care profession. Pilot programs are developed to test the applicability of the standards and procedures to new settings.

In response to an expressed need for more training and education in quality assurance and accreditation standards and procedures, AAAHC provides education programs and presentations at major ambulatory health care meetings each year. Full-length educational programming is the next step planned.

Though change is an inherent part of its philosophy, AAAHC's basic principles remain firmly intact. AAAHC intends to continue its tradition of using practicing physicians, administrators, and other health care professionals to conduct its accreditation surveys. More than 200 individuals from 42 states volunteer their time to AAAHC activities. Members of the Board of Directors are also trained as surveyors and participate in the peer-review process in making accreditation decisions.

Since its founding, AAAHC has conducted hundreds of accreditation surveys of all types of ambulatory care organizations, including ambulatory surgery facilities, college and university health services, community and neighborhood health centers, single and multi-specialty group practices, and health maintenance organizations.

Because of the quality of the standards and thoroughness of its surveys, AAAHC has been recognized and accepted by all types of third-party payors (Blue Cross and Blue Shield plans, commercial carriers, HMOs, governmental agencies) as meeting their conditions for participation in reimbursement programs. In recognition of the requirements for risk control and a quality assurance program in AAAHC's standards, a number of major professional liability carriers extend a discount in premium coverage to ambulatory surgery centers and to single and multi-specialty group practices accredited by AAAHC. CHAMPUS has cited AAAHC as an appropriate accreditation agency.

The Future of AAAHC

Since its founding, AAAHC's accreditation program has steadily gained acceptance and recognition from the health care community, government, and the general public. Now it has established itself as a leader in the maintenance and development of high-quality, cost-effective health care in the United States.

The continued growth and success of AAAHC is assured because of the commitment of ambulatory health care professionals to improve the quality of care provided in their organizations, to compare their performance to recognized standards, and to share their experiences through education and consultation.

The leaders and participants in AAAHC believe that a voluntary, pluralistic, peer-based approach will continue to improve health care services by fostering innovation and providing motivation. Above all, they believe that the ultimate benefactors of accreditation will always be the patients they serve.

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Presented To:

Committee on Small Business
Subcommittee on Regulation, Business Opportunities and Energy

June 28, 1989

by: Howard A. Tobin, M.D., F.A.C.S.
6300 Humana Plaza, Abilene, Texas 79606

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Mr. Chairman and members of the subcommittee, I am pleased to have the opportunity to present this information to you in response to your invitation. You have asked a number of questions related to your investigation which is now focusing on the issue of accreditation, and I will try to focus on the issues of whether or not there is a need for mandatory accreditation, as well as those issues raised by your other questions related to qualifications in cosmetic surgery, certification and advertising.

I want you to clearly understand that the opinions that I express are my own, and do not necessarily reflect the opinions of any specific organization , although I am active in several of the organizations that have already testified or are in the process of testifying. Specifically, I currently serve on the Board of Directors of the Accreditation Association for Ambulatory Health Care, I am the Chairman of the Ambulatory Surgery Committee of the American Academy of Facial Plastic & Reconstructive Surgery and the Chairman of the Public Relations Committee of the American Academy of Cosmetic Surgery. In addition, I serve as an examininer for the American Board of Cosmetic Surgery.

I first learned about your investigation in January of this year. Over a period of months, during which time I had extensive communication with your investigators, I became hopeful that this investigation might uncover some of the problems in the field that have largely stemmed from the efforts of various individuals and organizations to limit competition in cosmetic surgery. Frankly, from the very onset, it became apparent that what led to this investigation was that same interspecialty rivalry that has raged between competing groups of doctors who were engaged in the practice of cosmetic surgery.

You have already heard testimony from a number of individuals representing the American Academy of Cosmetic Surgery, the American Academy of Facial Plastic and Reconstructive Surgery, the American Academy of Dermatology as well as the American Society of Plastic and Reconstructive Surgeons. It must have become apparent to you, as a result of this testimony, that each of these groups, individually, is striving to improve cosmetic surgical care. Unfortunately, in some cases this does not extend to a recognition of the fact that, as in all aspects of medicine, there are a variety of possible solutions to every problem. It has long been an accepted tenant of medicine, that different specialties may deal with the same problem, and no one specialty should have a monopoly in a given area of medicine.

Interspecialty Conflict

In my surgical career, I have been involved in a number of interspecialty disputes, or as they are generally known - "turf battles". Since my initial background was in the field of head & neck cancer surgery, I first became a part of the controversy over who should do thyroid surgery, who should do bronchoscopy as well as who should carry out the reconstructive surgery that followed the removal of major tumors. Similar disputes have arisen in the areas of hand and back surgery. Some of these battles were settled and some still wage. Never, however, have I seen a battle that has taken on the intensity of this dispute over the right to practice cosmetic surgery. Unfortunately, the allegations by certain individuals that members of other specialties are inadequately trained or incompetent to perform cosmetic surgery have presented a picture that is far bleaker than reality. The vast majority of doctors, regardless of their speciality or background, who engage in cosmetic surgery - whether as a sole specialty or as a part of their practice in another field, are doing a responsible and credible job.

In the invitation extended to me, requesting my testimony before this committee, you stated that "the common thread through all the subcommittee's investigations has been 1) inappropriate use and lack of credentials, 2) misuse of medical technologies, 3) no minimum standards for outpatient facilities and 4) false or misleading advertising". I will attempt to address all of these issues as I deal with the role of accreditation as it relates to outpatient cosmetic surgery.

Outpatient Cosmetic Surgery

To bring this discussion into perspective, we must understand that the move toward outpatient surgery is certainly not unique to cosmetic surgery. Furthermore, outpatient surgery is not at all new. I am old enough to remember visiting a general practitioner's office in my home town and watching tonsillectomies done under open drip ether. At that time, it was the standard of care. We have subsequently moved through an era when it was unheard of for a child to undergo a tonsillectomy outside of the hospital. Now, once again, we recognize that when done under proper conditions, this operation can very safely be done on an outpatient basis.

Unfortunately, it is an oversimplification to try to decide whether "cosmetic surgery" should be done in a hospital, a surgical center, a doctor's office or any other specific type of facility. For example, in my practice, occasionally patients will come with a small mole on the face. Certainly, I don't need the same facility for this type of cosmetic surgery as I would for something as complex as a breast reduction or facelift. Therefore, when we talk about minimum standards for outpatient facilities, we have to consider all of the variables that enter into the decision as to where the operation will be performed. No one would deny that there has been virtually an explosive trend towards outpatient surgery. Frankly, on the whole, this seems to be a very healthy direction. By and large we find that not only do we see faster recovery and a lower infection rate, we have also seen modifications in technique that have represented significant improvements over those which were once considered a standard part of hospital care.

I became involved in outpatient surgery in 1974. At that time, I was first beginning to develop an interest in cosmetic surgery. I recognized that patients who were seeking this type of treatment could not expect reimbursement from their insurance company. I was frankly looking for a cheaper way to provide the desired services. At that time, I established an operating room in my office that I felt was adequate for the types of procedures that we were then carrying out. Compared to what I have now, this was a very modest facility, but still had adequate staff with adequate training, as well as the necessary equipment which allowed us to be prepared for emergencies. At that time, I knew of no outside organization available to me that could offer peer based guidance as to a standard of care in this area.

Shortly thereafter, I learned of the Accreditation Association for Ambulatory Healthcare (AAAHC). I applied for accreditation, and in going through the accreditation process learned much. There is no question that it allowed us to improve our care. Nevertheless, I would still maintain that prior to our accreditation, we were providing safe and effective care to our patients.

Accreditation as a Demonstration of the Pursuit of Excellence

The general concept of accreditation has been extremely important to me in my professional life. Fully twenty percent of my time is dedicated to voluntary activity directly or indirectly related to the accreditation process. You must understand that the remarks that I make are the result of of countless hours spent working with individuals and organizations in an effort to improve the delivery of outpatient cosmetic surgical care. I have seen a great deal of change.

As a director of AAAHC, I serve as the representative of the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS). You have previously heard the testimony of many distinguished representatives of that organization. Among them was our current President, Frank Kamer, M.D., who first asked me to serve on the board of AAAHC. Dr. Kamer was one of the early pioneers in the field of office based surgery, and was the first member of AAFPRS to have his surgical facility accredited. However, he is only one of many leaders in that organization who are committed to promoting high quality office based surgery amongst its members. The American Academy of Facial Plastic and Reconstructive Surgery works toward that goal in a number of ways. One very important way is through its affiliation with AAAHC. However, it is not the position of the Academy that AAAHC accreditation is the only means by which a surgeon can develop a safe and effective office based operating environment.

The Academy sees accreditation as the ideal, where surgeons can operate office based surgical units which undergo a formal program of voluntary peer review. We have worked diligently to encourage our members to seek voluntary accreditation. To date, however, a relatively small percentage of our members have done so. I am not sure of the exact number but I would assume that it's somewhere around twenty or so. Certainly, it is growing at an increasing rate. At times, I have become discouraged, since I had hoped that the number would be larger. However, I realize that the small number is somewhat misleading. First of all, the road to accreditation is not easy. It takes many many months for a facility to prepare for an accreditation survey. But there is a far greater reason why many facilities do not seek accreditation.

At the present time, incentives for accreditation are woefully lacking. At the conclusion of my remarks, I will have some suggestions for you which, I feel, can help to increase these incentives. Let me briefly explain to you some of the reasons why I feel that many surgeons are reluctant to pursue accreditation.

Office based surgical units have a very difficult time obtaining insurance reimbursement. Many individuals had hoped that accreditation would facilitate third party reimbursement. This has, unfortunately, been an exception rather than a rule. Of greater importance is the fact that in the field of cosmetic surgery, insurance reimbursement plays a much more limited role.

What then are the the incentives for accreditation? For the most part, the pride that comes from achieving accreditation is the primary motivating factor for most individuals. There still remain many surgeons who operate first class office based surgical units but who simply choose not to seek voluntary accreditation. As I previously mentioned, the American

Academy of Facial Plastic and Reconstructive Surgery expends a great deal of effort in educating its members in the area of outpatient surgery. In spite of the fact that a relatively small percentage of our members have achieved accreditation, we are convinced that most of them are benefiting from our educational efforts and are operating their facilities safely.

Accreditation was never intended to be the minimum level of outpatient healthcare delivery. In fact, the opposite is the case. It is intended to represent the highest standard. There is no question that we will see increasing numbers of doctors electing to achieve accreditation for their facilities. This is goal which we should encourage. Nevertheless, it would be highly misleading to even suggest that most doctors who work in operating facilities that are unaccredited are not meeting what would be considered minimum safe standards.

The American Academy of Facial Plastic and Reconstructive Surgery will continue to emphasize accreditation as an important goal for its members who operate in their own surgical facilities. It will also continue to emphasize high standards of care for those who elect not to achieve accreditation.

If this subcommittee is of the opinion that accreditation should be obligatory for cosmetic surgeons, it must realize that cosmetic surgery is only one small component of the overall move toward outpatient and office based surgery. There are many other specialities in which a similar change is taking place. I practice in a community of one hundred thousand people. In our town, individual doctors in the field of urology, ophthalmology, plastic surgery and otolaryngology: as well as cosmetic surgery are operating in office based surgical units. In addition to this, of course, there may be many other doctors who do some limited office surgery without specifically designating an "office operating room". In these other specialties, we do not see a more rapid move toward accreditation.

There are many forces in the medical marketplace that already exist to insure that doctors who choose to operate in their own facilities will provide a safe and effective environment for their patients.

Frankly, with the malpractice crisis as it exists today, doctors will voluntarily move toward accreditation simply to bolster their defense in a potential malpractice suit. This is not to say that lack of accreditation would be evidence of negligence, but there is no question that it would be easier to prove that they had achieved a proper standard of care if they can demonstrate their accreditation certificate. Accreditation is not the only evidence that a surgeon is providing the highest possible level of care, but it is certainly a good one.

In addition to my responsibilities in the American Academy of Facial Plastic and Reconstructive Surgery, I have also had the opportunity to serve as the Chairman of the Ambulatory Surgical Committee of the American Academy of Cosmetic Surgery (AACS). This is a new organization representing doctors in a new specialty. I have been pleased to see that since its inception, it has demonstrated a strong commitment toward educating its members in the area of safe outpatient surgical care.

Dr. Richard Webster, the first president of this organization, recognized from the outset that this would be an important area of concern. His first act as president was to establish an ambulatory surgical committee to study ways to promote high quality office based surgical care. Subsequent presidents have maintained the momentum in this direction.

By now, the members of this committee are well aware of the attacks that have been leveled against the American Academy of Cosmetic Surgery by certain leaders in the field of plastic and reconstructive surgery. Yet, I would insist that there is no organization that has taken a stronger position in support of urging its members to achieve accreditation. In fact, the American Academy of Cosmetic Surgery has applied for a position as a sponsoring member of the Accreditation Association for Ambulatory Healthcare.

I was disappointed when, at the last board of directors meeting of AAAHC, this application was delayed. At the time, the AAAHC board felt that they simply were overburdened with work and were not in the position to accept the challenge that would have accompanied the incorporation of a new sponsoring member. I regret this because I felt that the American Academy of Cosmetic Surgery was making the strongest possible commitment to encourage their members to work towards voluntary accreditation. This delay in acceptance by AAAHC will unfortunately have negative influence on the leadership of the American Academy of Cosmetic Surgery's efforts to encourage its members in this direction. Although I recognize that AAAHC is severely challanged by its mission, in the face of limited financial resources, I feel that it must find ways to live up to the challenge of remaining the preeminent accrediting organization for outpatient health care delivery.

As we all recognize, there is a need to provide high quality peer based review for surgeons in the field of cosmetic surgery. I feel that the appropriate agency to provide this review is AAAHC, and I certainly hope that in the very near future the board will agree to take on the responsibility of including representatives of organizations such as AACS as part of the board of directors.

The American Board of Cosmetic Surgery (ABCS) has also made a very firm commitment to encourage voluntary accreditation. This Board is taking the unprecedented step of considering the requirement of accreditation for its newly certified members who do the majority of their work in office based surgical units. It was the ABCS's intention to require AAAHC accreditation. Unfortunately, again the failure of the Board of AAAHC to accept AACS's application for sponsoring membership will certainly interfere with the American Board of Cosmetic Surgery's plans taken in this direction.

I would be remiss if I did not stress at this point that AAAHC accreditation is certainly available to all members of the American Academy of Cosmetic Surgery, as well as to any other individual whose facility meets the standards. Nevertheless, it is certainly understandable that the leadership of the American Academy of Cosmetic Surgery would be reluctant to strongly push their members in one direction when they have no participation in the accrediting organization. I sincerely hope that in the very near future, AAAHC will be able to act favorably toward this application. If not, I am afraid that the American Academy of Cosmetic Surgery may move towards the establishment of its own accrediting organization - a potential move that I personally feel is far less satisfactory.

Who Should do the Accrediting?

Today, you will also hear testimony by representatives of an accrediting organization that represents the members of the American Society of Plastic and

Reconstructive Surgery (ASPRS). This is an example of an organization that has essentially created its own system of accreditation. It is certainly not my intention to criticize the goals or accomplishments of that body. I do feel, however, that it is important to point out one very major difference between this organization and AAAHC. AAAHC was formed to provide peer based review for a variety of ambulatory healthcare facilities. It is based upon the premise that generic standards can be developed which apply to a multitude of practice situations.

One of the major advantages of this system is that it avoids the possibility of being a self serving organization to its members. This is an extremely important concept because of the fact that there is indeed competition in medicine. To a certain degree, competition is healthy. It is also important to have the participation of many different specialists in a peer based review organization. Indeed, I would say that this is the lifeblood of AAAHC. Representatives of ASPRS have conducted dialogue with AAAHC with an aim toward joining with us and having AAAHC carry out accreditation of their members' facilities, and I certainly would hope that these efforts continue.

A multi-disciplinary accreditation organization is bound to be superior to one that is controlled by a single specialty or organization and therefore more susceptible to incestuous influences.

Credentialing and Hospital Politics

When practitioners from different backgrounds and disciplines offer similar services, the public benefits through the choices which they are offered. Unfortunately, this type of competition is often stifled in a hospital setting.

When freestanding surgical centers were developed, it was the hospitals that primarily opposed their formulation. It was not because there was evidence that the standard of care would be lower in an outpatient surgical facility, but rather the determination on the part of hospitals to stifle the competition that would come from these alternate care facilities that were felt to be "skimming the cream off the top".

Hospital politics have long been recognized to be grossly unfair in many circumstances. Nowhere is this better exemplified than in the arena of granting surgical privileges.

In spite of the fact that it has been a long recognized tenet of medicine that doctors from various specialties should be allowed to perform the same procedures, turf battles have raged and continue to rage in hospitals throughout the land. One of the best examples of this type of turf battle has been in the area of liposuction surgery. Liposuction surgery is a new method of body contouring that has become extremely popular in a very short period of time. This is of importance since it emphasizes the fact that virtually everyone who has learned the procedure did so outside of the formal medical teaching programs.

Frankly, it is a relatively simple procedure that can easily be learned. Certainly, like any operation, it must be treated with due respect, but it is not difficult to develop the needed skills. Many different specialties have become interested in the procedure, and it has probably become the focal point of the cosmetic surgical dispute. Rather than elaborate on this one issue here, I have attached a copy of an address which I delivered to a meeting of the Federated Ambulatory Surgical Association last year which deals with credentialing in liposuction surgery. I urge you to read this address, since it will give you additional insight into the argument over credentialing in liposuction surgery in particular and cosmetic surgery in general.

There is no question that there are many instances where doctors have been denied privileges to do an operation in a hospital and are carrying out that same procedure in an ambulatory surgical facility. This does not necessarily mean that the doctor is not qualified to carry out the operation. It may simply be a reflection of the fact that the credentials committee at the local hospital was controlled by vested interests that were attempting to stifle competition. Much of this unfair limiting of surgical privileges has been fostered by plastic surgeons who insist that only members of their specialty have adequate training to carry out cosmetic surgery.

Unfortunately, once the requesting surgeon is denied his request, he is further outlawed by the ruse thay he "lacks hospital privileges." In the past, physicians wronged in this way have had no recourse, but we are beginning to see a change, as this problem has been brought into sharp focus by the case of Timothy Patrick, M. D., who wrongfully had his privileges revoked because of anticompetative actions by his peers. Paul G. Gebhard, LLB and Douglas J. Polk, JD, legal cousels for the American College of Surgeons summarized the case in the Vol. 73 No. 10 issue of the American College of Surgeons Bulletin as follows:

> "Courts have generally been quite protective of the process of medical peer review and respectful of the informed judgements of physicians in technical medical matters beyond the ken of non-physicians. But when peer review involves not so much scientific matters as matters with which lawyers and judges are more familiar, such as a concerted effort by a group of competitors to eliminate competition from a new entrant into their local market, courts are no longer reticent to sit in judgment on the processes and on the results of peer review, or on the motivations of those engaged in peer review. Thus, in the recent ***Patrick v. Burget*** decision, the United States Supreme Court upheld a multimillion dollar jury verdict under the federal antitrust laws against individual members of a hospital peer review committee who engaged in anti-competitive conduct under the guise of peer review of a competing surgeon"

AAAHC is well aware of this credentialing problem. For this reason, AAAHC accreditation requires that independent credentialing be carried out. That is to say that a surgeon should not simply be granted or denied privileges based on privileges that he holds in a hospital.

Until we are able to achieve a system where credentialling becomes a fair and impartial process, we must resist any temptation to assume that a surgeon is unqualified in a procedure simply because he has been denied privileges at a given facility.

The above should not be construed to suggest that a surgeon should carry out procedures in an outpatient facility or in an office based facility when he is unqualified. Certainly, surgeons should be limited to performing those procedures in which they have adequate training, experience and ability. It behooves us as physicians to develop means by which we can honestly evaluate our colleagues and, at that same time, provide for means by which they can expand their horizons.

In his testimony before you in April, Dr. Richard Webster very clearly pointed out that most of us in the field of cosmetic surgery are now performing procedures in which we had little or no original formal training. In his Presidential address to the American Society for Aesthetic Plastic Surgery, Dr. Thomas Baker an eminent plastic and reconstructive surgeon, reminded his colleagues that the training received by a plastic surgery resident is often woefully lacking. Dr. Baker, who is renowned as one of the most outstanding cosmetic plastic surgeons in the world, stated that "in my particular training program, little or no aesthetic surgery was done, especially by the residents." (*Plastic & Reconstructive Surgery, November 1982 p 600-604*).

Medicine consists of a constant learning process. This is certainly true in the area of cosmetic surgery. There has been such increased interest and so many changes, that few experienced cosmetic surgeons would even suggest that their original residency training did more than prepare the way for them to learn their craft.

In an ideal world, surgeons from various specialities would work together towards educating their colleagues from different fields and sharing knowledge. This is the way medicine was meant to be. If indeed the leadership of the American Society of Plastic and Reconstructive Surgery is so concerned about unqualified doctors engaged in the practice of cosmetic surgery, I would challenge them to work with the leaders of the various other organizations to develop joint programs which would provide education in the areas where they feel these practitioners are lacking. This is one way in which we can all work together to improve the quality of cosmetic surgery. Unfortunately, now we find various speciality groups jealously guarding their knowledge and expending their major efforts in an attempt to convince the public that they alone are capable of providing care.

Advertising the Turf War

In my opinion, the epitome of this type of self-serving publicity has been carried out by a group of plastic surgeons in Dallas, Texas, who have mounted a persistent advertising campaign based on trying to convince the public that they are the only individuals qualified to provide cosmetic surgery care. This advertising seems particularly deceptive since they single out the American Board of Cosmetic Surgery, which they emphasize as being "not recognized by the American Board of Medical Specialties," as if that alone was evidence of inferiority. This advertising campaign was mounted purely in an effort to discourage competition. Not only were advertisements run in the newspaper, but one of the members of this society wrote an editorial in a newspaper which referred to this congressional hearing and used it to bolster his argument that only plastic and reconstructive surgeons who are certified by the American Board of Plastic Surgery are qualified in the field of cosmetic surgery.

By now you have heard enough testimony to recognize that plastic and reconstructive surgery is a very broad field. Although some members of that specialty may emphasize cosmetic surgery, there are many who have little or no training in the field and have even less practical experience in cosmetic surgical procedures. Yet, they would insist that certification by their board is consistently more meaningful than certification by the American Board of Cosmetic Surgery which requires a surgeon to have demonstrated knowledge based on examination as well as experience based on the performance of over one thousand cosmetic cases.

I would suggest to you that when a group of physicians claim that their specialty possesses a monoply on knowlege and skill, they are really asking for a monopoly on profits!

In response to that editorial, I wrote to the newspaper and offered a rebuttal. Although it was not accepted, I have enclosed a copy of my statement and would urge you to read it.

Advertising in Cosmetic Surgery

The final issue that you have asked me to address is that of advertising. At past hearings, you have displayed a number of advertisements which you feel to be inappropriate. I also find some of the advertising in cosmetic surgery to be personally distasteful. Frankly, it is my opinion that consumers have the sense to recognize when they are being educated and when they are being sold.

Consumers do, however, deserve a choice, and advertising is one means by which they can become educated about the choices open to them. To deny advertising simply allows the entrenched surgeon to prevent competition, and this is not to the advantage of the consumer.

In spite of some of the rather overpowering ads that you have displayed, there is much advertising in cosmetic surgery that I think is positive. Advertising is certainly not limited to cosmetic surgery. We see far more ads for hospitals, drug rehabilitation programs, alcohol rehabilitation programs and clinics than we do for cosmetic surgery. However, it is not surprising that cosmetic surgeons do tend to advertise. Cosmetic surgery is highly elective. Patients have it out of desire rather than need. They come to cosmetic surgeons from outside of the routine referral patterns of medicine. For young doctors coming out of training and choosing to initially limit their practice to cosmetic surgery, there is little other way for them to attract patients.

In my own practice, I have chosen to advertise to a rather limited extent. I feel that the ads that I run are honest and are not in any way misleading to prospective patients. Frankly, I have had a number of patients comment favorably upon the ads. They stated that they appreciated my services and would not have been aware of them had they not read the advertisement. I have included one such letter from a patient who specifically wrote to me after her surgery to tell me how meaningful the advertisement was in her life.

I would not deny that there are abuses in all types of medical advertising. I do not think that these abuses should be condoned. State regulatory agencies and local medical societies all have guidelines defining acceptable medical advertising. If a doctor strays beyond what is honest and true, he should be held accountable. I know that in my state, the Texas Board of Medical Examiners has strict limitations on what is acceptable in medical advertising. Many feel that they are overly strict. I assume that similar restrictions exist in other states.

Suggestions for the Subcommittee

This committee has spent many hours investigating the field of cosmetic surgery. I know that you are anxious to help, and to serve the public. I know that one of your goals is to help to encourage accreditation. I certainly share your enthusiasm in this area. However, I feel strongly that accreditation can function best in a deregulated environment which is likely to ultimately benefit the consumer. I would agree that optional accreditation should be strongly supported. Perhaps I can offer a few suggestions about what I think the Federal Government can do to help us become more successful in encouraging voluntary accreditation.

For several years, AAAHC has been attempting to work with HCFA (Healthcare Financing Administration) to establish a process whereby AAAHC accreditation could serve as a means by which a facility could simultaneously achieve medicare certification. The type of program has long existed in the hospital arena as a result of agreements between HCFA and The Joint Commission for Healthcare Organizations. It is called *deemed status*. Early in my discussion, I mentioned to you that there were few incentives for voluntary accreditation. Medicare certification would be a powerful incentive since it serves as the basis for reimbursement by most insurance companies. At the present time, those of us who choose to comply with Medicare requirements must go through a dual certification process. This becomes time consuming and creates a great deal of additional unnecessary paperwork. I can tell you this from experience since we voluntarily choose to achieve both forms of certification.

After a great deal of effort, AAAHC was able to modify its standards such that they dovetailed with those of HCFA. We were in a position whereby we could offer a survey process that would insure that the organization would meet the high standards of AAAHC as well as the requirement of Medicare. As negotiations proceeded, we always seemed to be at the brink of final agreement. Unfortunately, we were never able to conclude the settlement which would lead to deemed status.

AAAHC had expended a great deal of time, money and effort which unfortunately had also been needed for other types of work. Furthermore, as I have mentioned, many surgeons had delayed their plans to seek accreditation, since they felt that they should not go forward until they were sure that the government would not impose new requirement with which they might not be in a position to comply.

All of the time and effort expended by AAAHC, that was felt to be a potential source of encouragement for voluntary accreditation ultimately has had the opposite effect.

This committee could serve a very valuable purpose if it would use its influence to prevail upon HCFA to grant deemed status to AAAHC. Additionally, you may be able to provide help in convincing private insurance companies to offer reimbursement to surgical facilities that are accredited by AAAHC. This would not only encourage accreditation, but would save the insurance companies money, since they often end up paying far more for hospitalization or for surgery performed in a hospital outpatient department.

Another area in which I feel that this committee can be of value is in the area of public education. I feel that it would be entirely appropriate for the government to use its considerable resources to educate the public as to the benefits of accreditation. I have reiterated on numerous occasions that I am opposed to compulsory accreditation. Nevertheless, I am equally convinced that AAAHC accreditation remains the best available means by which a facility can demonstrate to its patients that it is providing high quality service. Recognition of this by the government would further encourage many more of my colleagues to make the effort to achieve accreditation.

In the state of California, we have embarked upon such a joint program with the

best copy available

Reproduced from poor document.

California Medical Association, and we anticipate a large increase in the number of office based surgical facilities seeking accreditation.

Finally, I would again remind you that AAAHC is a voluntary organization. Those of us who serve the organization do so because we believe firmly in the principle of unforced peer based review. The organization is funded primarily by our member organizations who have been generous to a fault. We, as individuals, ask no compensation for our services. Our surveyors all donate their time as do the officers and members of the board. However, you must understand that it is expensive to provide the kinds of services that are required. I know little about government funding, except for the fact that strings are always attached. Nevertheless, I feel that the organization would be highly deserving of any financial assistance that the government can offer. Perhaps you can give leadership in this direction.

Certainly I, as an involved individual, or any of the organizations that I represent, would be more than willing to work with this or any other committee to develop standards for office based surgery. However, I feel that it is inappropriate to single out cosmetic surgery for this type of investigation, since the vast majority of doctors who practice cosmetic surgery do so as a part of another specialty. There are very few physicians who truly limit their practice to cosmetic surgery.

Conclusion

As I conclude my presentation, I would hope that upon careful reflection of the evidence that this committee has studied over the past few months, it will use its considerable influence to attempt to discourage those members of the medical profession who would attempt to stifle free competition in the field of medicine.

There are many doctors who are members of all of the societies who have appeared before this committee that are dedicated to providing their patients with the best possible care. We realize that we are fallible and far from perfect. But day after day, we try to learn to improve our skills and to treat our patients with care, honesty and compassion. I am deeply saddened by the bitter fighting that has occurred in an area of medicine that I feel to be extremely important, and to which I have dedicated my life.

In my clinic, in each of our guest suites, we have a book where patients can leave a message for others. I often look at the pages of that book and read the notes expressing the thanks and appreciation of my patients. Cosmetic surgery is a wonderful field. There is plenty of work for all of us who are willing to spend the time and effort required to learn how to provide this type of care for our patients. There are many avenues that can lead toward a successful cosmetic surgery practice. All of us can learn from our colleagues.

Perhaps you, who have had the opportunity to look at all sides of this issue, can help to bring us together in our common goals of serving the public good.

Thank you.

Credentialling in Liposuction Surgery

Based upon an invited talk given By Howard A. Tobin, M. D. at the annual meeting of F.A.S.A. - Federated Ambulatory Surgical Association.
May 12, 1988 - Washington D.C.

> **"They just stared. Maybe they didn't hear me. Maybe I didn't hear them. Or maybe they thought I was just a crazy fool. An hour later I saw land.**
> **Charles A Lindbergh**
> **New York Times May 23 1927**

The awarding of privileges focuses upon a crucial subject in interspecialty relations. Although liposuction surgery is the hot topic of today, really our discussion relates to an issue that goes beyond liposuction surgery because this is just an example of the types of problems that we're facing in medicine and in outpatient surgery. It's interesting that with liposuction surgery, for the first time, we have a group of people coming from different specialties all of whom are just learning the same thing. It is representative of the increased competition in medicine. Unfortunately competition often brings on discord and for the first time, what we're finding is that doctors are exactly like everybody else in conflict. They're struggling to capture a market share. In many cases, old established rules and guidelines are being broken - sometimes for the better, and sometimes for the worse.

> **"All animals are equal, but some animals are more equal that others."**
> **George Orwell from**
> **Animal Farm 1945**

In regard to credentialling, there are some clearly established guidelines and principals from some of the prestigious organizations in medicine. When examined as a whole, it would appear that the principals guiding the concept of credentialling individuals adopting a new procedure should be fairly clear. Now I wish that I could just tell you that all you need to do is look at these rules, but rules don't mean everything because decisions aren't made purely on basis of who meets agreed upon written criteria. There is an extensive amount of interpretation that enters into the final selection process.

Let's first take an overview of how such an evaluation of competency in a new procedure might take place in an ideal setting. Presumably, you want to make sure the individual has adequate training. How do you get training? There are lots of ways. You can take it during your residency. Of course, that probably doesn't pertain to liposuction surgery right now because the training programs are just beginning to train physicians in this technique, and the doctors who teach in these programs have barely learned the procedures themselves.

So you can learn it through postgraduate training. You take a workshop or a preceptorship and then somehow you've got begin to get a little experience, presumably first working with someone experienced in the procedure. Then you go to a credentials committee and you show them that you've learned how to do the procedure and try to convince them that you can do it in a safe and effective manner. Basically that's all it should take. It shouldn't be too much of a problem.

As stated, the major organizations have already given us some fairly clear criteria telling us how we should go about credentialing. The A.M.A. has very clearly said that individual character, training, competence, experience and judgement should be the criteria for granting privileges and clearly states that physicians from many specialties may be doing the same types of procedures[1]. The same opinion has been expressed by the American College of Surgeons which stated that the eligibility to perform hospital surgical procedures as the responsible surgeon must be based on an individual's education, his training, his experience and his demonstrated proficiency[2]. And they have some criteria on what you do if your trying to request privileges in an area that's a little bit outside of your basic training. They say that simply, you've got to show that you've been trained to do it. That you know how to do the procedure, and can do it safely and effectively!

The Joint Commission of Accreditation of Health Organizations (J.C.A.H.) has come out with the same sort of statement regarding primary training out side of one's original discipline. You simply have to have appropriate training and experience; and I would stress to you that they're talking about procedures that the applicant has not been formally taught in a residency program - and this is crucial because in liposuction surgery we're talking about nearly everybody. There is no specialty that has a *background* in liposuction surgery. This territory is all brand new. No residency was teaching it. It was just introduced to this country a few years ago, and so every doctor that looks for privileges is on the same foot. He has the same responsibility to show that he has proper training and proper experience, and that training and experience doesn't come from his residency.

Now, even the American Board of Medical Specialties has made some statements about this type of credentialling. They clearly state that specialty training is only one of several valid and important criteria in granting privileges; and in a statement made in 1977, the ABMS recognized that the process of granting clinical privileges within a hospital setting is distinctly different from that involved in the delineation of medical specialty certification[3] .

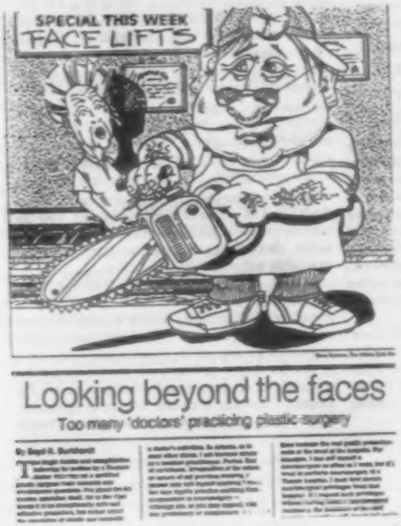
The Accreditation Association for Ambulatory Health Care (A.A.A.H.C.) is a leading organization involved in the peer based review of ambulatory surgical facilities. Its standards clearly state that credentialing is to be based on education, training, experience, and competence, not me[illegible] on what your primary specialty was or is[4]. It may play a part, but that's not the final issue

After all, my background is in otolaryngology. In my field there are many people who do very sophisticated and major cancer surgery. Now that individual is clearly different from an otolaryngologist who confines his practice to the treatment of allergy, or someone who does ear surgery. The fact that I originally started in otolaryngology and took my residency in that field some twenty years ago may have very little to do with what I'm actually doing now.

So here's where the issue starts and here's where we are now. Unfortunately, instead of trying to solve the problem within the medical profession, it's been carried out to the public in the form of lay articles and press releases, and this has gone to a far greater extent than anyone would have ever imagined in the field of medicine. Articles such as the one shown here, have appeared in newspapers.

In this particular case, editorial comment was offered by an individual who was clearly attempting to convince readers that board certified plastic surgeons were the only group of doctors who could be trusted to safely and effectively offer high quality cosmetic surgery. What was not stated in the article was the fact that the editorial writer was, himself, a plastic surgeon who has demonstrated considerable past effort to disparage other specialties that offer services in the broad area of cosmetic surgery. When examined with the accompanying cartoon, how can we expect that individuals like this writer, when serving on a credentials committee, are going to look at us fairly and try and give us our just recognition and actually look at our credentials?

Now the history of this type of disparagement goes back much earlier and it's interesting that the same individuals often seem to be involved. A case was recently settled in the Georgia Court of Appeals where a million and a half dollars was awarded to an otolaryngologist who was defamed by the Georgia Society of Plastic Surgeons. That successful suit was based upon a scathing article that stated that the otolaryngologist wasn't qualified to do facial plastic surgery and that the organizations to which he belonged to were simply shams



Looking beyond the faces

Too many 'doctors' practicing plastic surgery trying to cover up his inexperience and his inability to competently provide these services.

> **"[W]e have the power, ability and cohesiveness of our members to stall and frustrate the majority of their [otolaryngologist's] efforts to achieve national recognition from organized medical societies."**
>
> **ASPRS headquarters memo**
> **Plaintiff's exhibit #4 Anderson vs. Georgia Soc. Plastic Surgeons.**

During that trial some interesting things came out. The Federal Trade Commission had carried out an investigation of the plastic and reconstructive surgeons' organization and discovered some statements made that clearly demonstrated that one specialty had an organized policy of trying to limit other specialties from carrying out procedures that might be within their domain. Clearly anti-competitive behavior. It really has no place in medicine.

Even prior to this case in Georgia, the FTC had looked into this matter and there was supposed to be an amicable settlement in which the plastic and reconstructive surgeons had agreed to desist in this type of anti-competitive activity; and yet it didn't happen. Just recently again in Fort Worth, Texas the Federal Trade Commission was involved in an issue where limitations were being placed on the privilege of non plastic surgeons identifying themselves as cosmetic surgeons.

> **'[T]he [plastic surgeon's] conspiracy deceives consumers about the qualifications of these positions [otolaryngologists et. al.] and forecloses consumers from freedom of choice among physicians'**
>
> **FTC staff report**
> **Plaintiff's exhibit #11 Anderwson vs Georgia Soc. Plastic Surgeons**

Now I'm pleased to have Dr. Carson Lewis on the panel with us and I'm very interested in hearing what he has to say. Dr. Lewis, a highly respected plastic and reconstructive surgeon, was the president of the Lipolysis Society and he made some statements that I think are very interesting because I think that these statements are indicative of the type of activity that plastic and reconstructive surgeons engaged in to try and protect their turf in the area of liposuction surgery.

> **"More men have been elected between sundown and sunup than ever were elected between sunup and sundown"**
>
> **Will Rogers**
> **The Illeterate Digest 1924**

The battlegrounds appear to have been clearly drawn. Plastic and reconstructive surgeons have decided that they'll fight their war in three areas: one is in the area of limiting advertising , a subject that's outside of the scope of our discussion. The second is in the area of limiting the availability of non-plastic surgeons to obtain malpractice insurance. And finally to limit privileges. Dr. Lewis, in his President's message to the members of the "Lypololysis Society", recommended that the "best course of action is to curtail the number of lipoplasties performed by untrained physicians through the specification of hospital privileges and malpractice insurance coverage."[5] He goes on to state that "the procedure is a technique to enhance **existing** [emphasis mine] body-sculpting procedures." This statement implies to me that others should not be allowed to learn the procedure. Is that how doctors are supposed to compete? Is that how the neurosurgeons should compete with orthopedists in the area of performing disc surgery? Is this how we would have internists compete with surgeons over the issue of who should perform endoscopy. Is that how all of us are going to compete with our fellows - by trying to keep them from doing anything that we may also do?

The whole background of the development of liposuction surgery belies this concept. After all, where did the procedure come from? It originated in Europe, developed by a group of doctors from divers specialties.

> **"I wouldn't want to belong to any club that would accept me as a member"**
>
> **Groucho Marx**

The Journal of the Lipolysis Society, in its ———— ———— issue, credited Dr. Pierre Fournier with his magnificent contributions to liposuction surgery. Dr. Fournier's background is in general surgery. The same article credits Dr. Yves-Gerard Illouz and Dr. Georgio Fisher as being the pioneers of liposuction surgery. Dr. Illouz's training is in gynecology, orthopedics, and general surgery; and Dr. Fisher is an otolaryngologist. Here you have the fathers of liposuction surgery.

Well now, in honoring Pierre Fournier these surgeons have a little bit of a problem. Because they were distressed about one thing, and that was the fact that Dr. Fournier was teaching non plastic surgeons in this procedure. They tried to prevail upon Dr. Fournier to limit his teaching to plastic surgeons, as evidenced by Dr Lewis' statement that "Pierre has been controversial because of his willingness to teach all who are interested in his techniqes and methods."but concluded by stating that he "has agreed to confine his teaching in the United States to plastic surgeons."[6] Fortunately, Dr. Fournier decided that the procedure should be open to everyone, and so, many surgeons from varying primary specialties have studied under Dr. Fournier and learned from him - often going on to become leading liposuction surgeons. People in all different specialties, dermatology, gynecology, otolaryngology, plastic surgery. And that's the way it should be .

Now the plastic and reconstructive surgeons claim that they should have a monopoly on this procedure because other people don't practice the alternatives to the operation. They say you can't do liposuction surgery if you don't know how to do a tummy tuck. This is an interesting argument. Extrapolating, I guess that would mean that chemotherapists are not qualified to treat cancer because they don't operate on the disease. And I guess that's true of the radiologists, too. They had better turn off those cobalt machines because they don't know how to do the surgery. Obviously that's a fallacious argument. We all know our own specialty. We all can't cover all of the possible alternatives. That's the whole basis of referral of patients to physicians who are more qualified in alternative areas.

"The greater the ignorance the greater the dogmatism."
Sir William Osler
Montreal Medical Journal 1902

Another tactic that was used by the plastic surgeons to attempt to convince the public that they were the most qualified to carry out this procedure was the press release. Recognizing the wide diversity of specialists offering liposuction surgery, they seized upon a rather spectacular death in Houston to attempt to convince the public that there was a much higher risk involved when a surgeon was not a board certified plastic and reconstructive surgeon[7]. Although the intent of this release was to encourage prospective patients to seek out members of this specialty for their surgery, it appeared to have backfired in the sense that many people were frightened away from having the operation done at all because of the apparent high risk. Perhaps this was the reason for a subsequent release that attempted to convince the public that, after all, liposuction was safe - but obviously much safer when carried out by a plastic and reconstructive surgeon who, presumably was able to offer alternatives unavailable from other who performed the operation.[8]

Another arguement often offered by plastic and reconstructive surgeons is that only they are qualified to perform liporuction surgery because of their ability to better handle complications that might arise.

Are we to believe that if a plastic and reconstructive surgeon perforated the abdomen, with perhaps two years of general surgery training, that he might have had fifteen or twenty years ago, he's going to jump right in and do a laparotomy? No. All of us, when we have complications, call on qualified consultants. We do the work that we are skilled in, and we seek help when we need it.

"Let us never negotiate out of fear, but let us never fear to negotiate."
John F. Kennedy
Inaugural address 1961

Well, I'm afraid I've painted a rather dismal picture to you. It doesn't have to be that way. There's plenty of room for all of us in this field. Liposuction surgery is a new horizon. We have not yet begun to respond to the potential demand for this operation and there is opportunity for all of us. Each of the specialties offering this service will develop new techniques and innovations. By pooling our knowledge and cooperating, all of us can provide better and safer care to our patients. Any group that feels that they have such superior knowledge and skill should be intent on educating others that may not have that skill or wisdom. That is the way in which medicine advances.

"The game isn't over till it's over."
Yogi Berra

lthough we have entered the era of liposuction urgery on a note of controversy, perhaps with the fforts of all well meaning and responsible physicians, ve can reach agreement, that agreement being that ve'll all work together to best serve our patients.

References

Delineation of Hospital Privileges - guidelines published ointly by the American Academy of Otolaryngolgy - Head & Neck Surgery, Inc. and the American Academy of Facial Plastic nd Reconstructive Surgery.

[2] ibid

[3] ibid

[4] **Accreditation Handbook for Ambulatory Health Care - 1987-88 Edition** Accreditation Association for Ambulatory Health Care, Inc. p. 29.

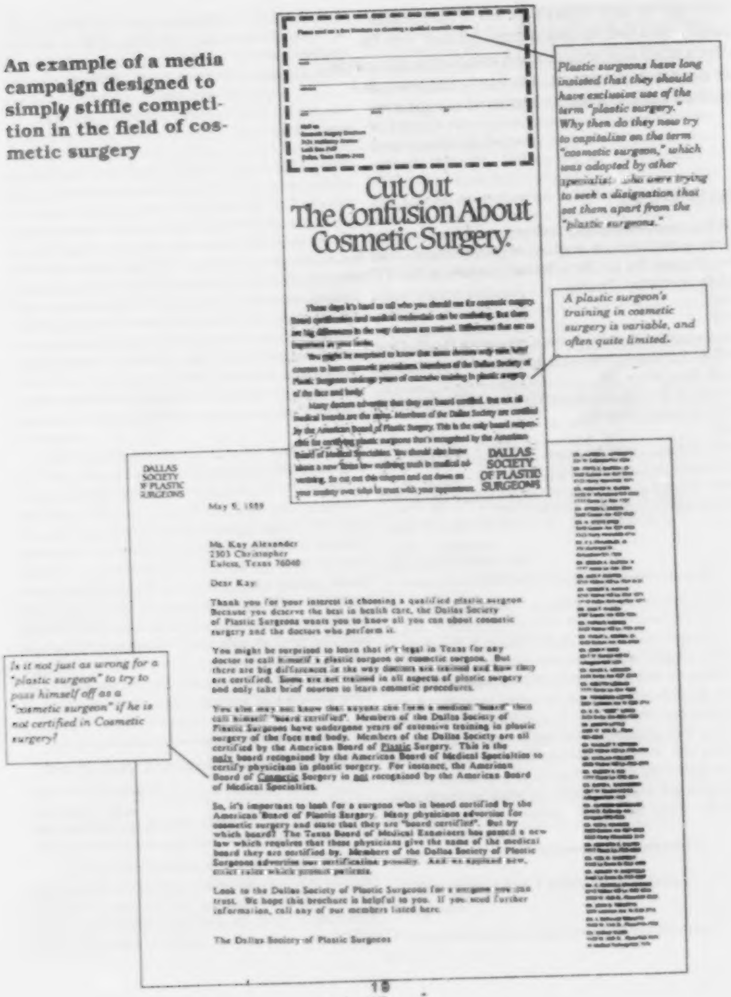
[5] Journal of the Lypololysis society - late 1987 **will have to check on exact reference**

[6] ibid

[7] News Release issued by American Society of Plastic And Reconstructive Surgeons - April 1987

[8] News Release issued by American Society of Plastic And Reconstructive Surgeons - October 1987

An example of a media campaign designed to simply stiffle competition in the field of cosmetic surgery



Plastic surgeons have long insisted that they should have exclusive use of the term "plastic surgery." Why then do they now try to capitalize on the term "cosmetic surgeon," which was adopted by other specialists who were trying to seek a disignation that set them apart from the "plastic surgeons."

A plastic surgeon's training in cosmetic surgery is variable, and often quite limited.

Is it not just as wrong for a "plastic surgeon" to try to pass himself off as a "cosmetic surgeon" if he is not certified in Cosmetic surgery?

Cut Out
The Confusion About
Cosmetic Surgery.

DALLAS SOCIETY OF PLASTIC SURGEONS

DALLAS
SOCIETY
OF PLASTIC
SURGEONS

May 5, 1989

Ms. Kay Alexander
2303 Christopher
Euless, Texas 76040

Dear Kay:

Thank you for your interest in choosing a qualified plastic surgeon. Because you deserve the best in health care, the Dallas Society of Plastic Surgeons wants you to know all you can about cosmetic surgery and the doctors who perform it.

You might be surprised to learn that it's legal in Texas for any doctor to call himself a plastic surgeon or cosmetic surgeon. But there are big differences in the way doctors are trained and how they are certified. Some are not trained in all aspects of plastic surgery and only take brief courses to learn cosmetic procedures.

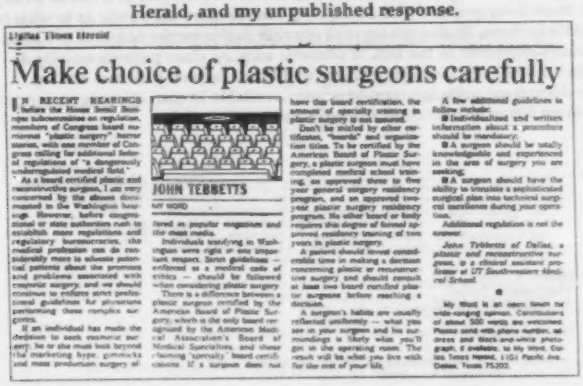
You also may not know that anyone can form a medical "board" then call himself "board certified". Members of the Dallas Society of Plastic Surgeons have undergone years of extensive training in plastic surgery of the face and body. Members of the Dallas Society are all certified by the American Board of Plastic Surgery. This is the only board recognized by the American Board of Medical Specialties to certify physicians in plastic surgery. For instance, the American Board of Cosmetic Surgery is not recognized by the American Board of Medical Specialties.

So, it's important to look for a surgeon who is board certified by the American Board of Plastic Surgery. Many physicians advertise for cosmetic surgery and state that they are "board certified". But by which board? The Texas Board of Medical Examiners has passed a new law which requires that these physicians give the name of the medical board they are certified by. Members of the Dallas Society of Plastic Surgeons advertise our certification proudly. And we applaud new, strict rules which protect patients.

Look to the Dallas Society of Plastic Surgeons for a surgeon you can trust. We hope this brochure is helpful to you. If you need further information, call any of our members listed here.

The Dallas Society of Plastic Surgeons

Submitted editorial of Dallas Plastic Surgeon in May 16, edition of Dallas Times Herald, and my unpublished response.



Dallas Times Herald

Make choice of plastic surgeons carefully

JOHN TEBBETTS

MY WORD

IN RECENT HEARINGS before the House Small Business subcommittee on regulation, members of Congress heard numerous "plastic surgery" horror stories, with one member of Congress calling for additional federal regulations of "a dangerously underregulated medical field."

As a board certified plastic and reconstructive surgeon, I am very concerned by the abuses documented in the Washington hearings. However, before congressional or state authorities rush to establish more regulations and regulatory bureaucracies, the medical profession can do considerably more to educate potential patients about the promises and problems associated with cosmetic surgery, and we should continue to enforce strict professional guidelines for physicians performing these complex surgeries.

If an individual has made the decision to seek cosmetic surgery, he or she must look beyond the marketing hype, gimmicks and mass production surgery offered in popular magazines and the mass media.

Individuals testifying in Washington were right in one important respect. Strict guidelines — enforced as a medical code of ethics — should be followed when considering plastic surgery.

There is a difference between a plastic surgeon certified by the American Board of Plastic Surgery, which is the only board recognized by the American Medical Association's Board of Medical Specialties, and those claiming "specialty" board certifications. If a surgeon does not have this board certification, the amount of specialty training in plastic surgery is not assured.

Don't be misled by other certificates, "boards" and organization titles. To be certified by the American Board of Plastic Surgery, a plastic surgeon must have completed medical school training, an approved three to five year general surgery residency program, and an approved two-year plastic surgery residency program. No other board or body requires this degree of formal approved residency training of two years in plastic surgery.

A patient should invest considerable time in making a decision concerning plastic or reconstructive surgery and should consult at least two board certified plastic surgeons before reaching a decision.

A surgeon's habits are usually reflected uniformly — what you see in your surgeon and his surroundings is likely what you'll get in the operating room. The result will be what you live with for the rest of your life.

A few additional guidelines to follow include:

- Individualized and written information about a procedure should be mandatory;
- A surgeon should be totally knowledgeable and experienced in the area of surgery you are seeking;
- A surgeon should have the ability to translate a sophisticated surgical plan into technical surgical excellence during your operation.

Additional regulation is not the answer.

John Tebbetts of Dallas, a plastic and reconstructive surgeon, is a clinical assistant professor at UT Southwestern Medical School.

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My Word is an open forum for wide-ranging opinion. Contributions of about 500 words are welcomed. Please send with phone number, address and black-and-white photograph, if available, to My Word, Dallas Times Herald, 1101 Pacific Ave., Dallas, Texas 75202.

May 19, 1989

My Word, Dallas Times Herald
1101 Pacific Ave.
Dallas, Texas 75202

Recently, Dr. John Tebbetts, a Dallas plastic surgeon, wrote in this column about congressional hearings into possible abuses in cosmetic surgery. One of the areas of concern is advertising abuses which deprive patients of the ability to make a fair and knowledgeable choice of surgeon.

Dr. Tebbetts' solution is that consumers limit their choice to members of his Society. His position is that which has been taken by the Dallas Society of Plastic Surgeons and which has been the subject of a massive advertising campaign of a magnitude that has never before been seen in this area. Their proposal is that if you choose a surgeon who has completed a two year plastic surgery residency, you are much more likely to find a skilled, competent cosmetic surgeon.

Unfortunately, the facts do not support this tenet.

In his Presidential address to the American Society for Aesthetic Plastic Surgery, Dr. Thomas Baker reminded his colleagues that the training received by a plastic surgery resident is often woefully lacking. Dr. Baker who is renowned as one of the most outstanding cosmetic plastic surgeons in the world stated that "in my particular training program, little or no aesthetic surgery was done, especially by the residents."

Why, then do plastic surgeons go to such great efforts to convince the public that a formal two year training program in plastic surgery is the most important criteria for the selection of a cosmetic surgeon? Why do they continually attempt to downgrade the American Board of Cosmetic Surgery which places its emphasis more on a surgeon's actual experience and ability than his basic formal training, which may have taken place many years ago?

Dr. Tebbetts warns us not to be misled by "other certificates". The requirements of the American Board of Cosmetic Surgery are clearly stated. To be certified, a surgeon must have already completed formal training in one of the more established disciplines and must either be board certified or board eligible in that original discipline. So much for the formal training requirement. Beyond that, the American Board of Cosmetic Surgery requires the candidate to have completed a thousand surgical cases, and be doing 500 cosmetic procedures a year.

Dr. Thomas Rees, another leader in plastic surgery, stated that in his residency he assisted in only ten facelifts and never did a single one*. Surely most consumers would like to know that their surgeon is experienced and has more than just book learning in the operation they are requesting.

The candidate for certification by the American Board of Cosmetic Surgery passes a rigorous examination based entirely upon cosmetic surgery. Isn't it significant to know that a surgeon was examined in the specific area of interest rather than in a broader field?

Unfortunately, turf battles such as this rarely serve the public. As much as all physicians would like our patients to be thoroughly informed and to thoroughly investigate all the ramifications of their choice of surgeon, advertising campaigns such as that carried out by the Dallas plastic surgeons only serve to confuse the issue.

The truth is that in every discipline, there are surgeons who range from excellent to poor. There is plenty of work for all competent surgeons. Hopefully, the day will come when doctors will be able to concentrate all their energies on serving their patients through providing high quality work and exchanging knowledge among their peers so that all patients may benefit. The public deserves no less.

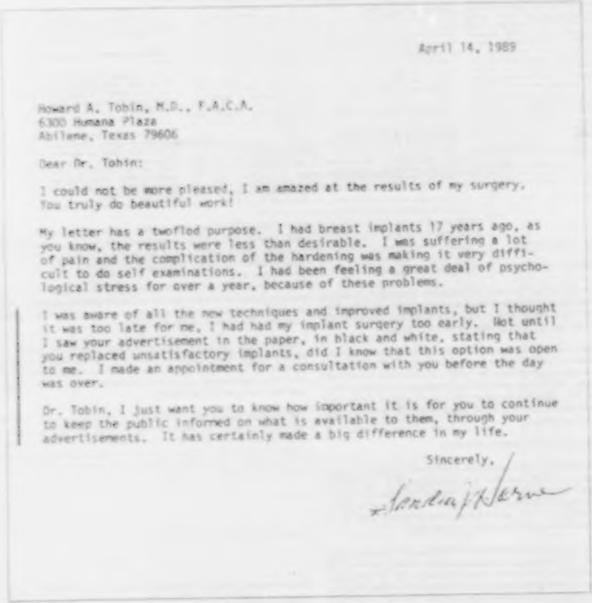
Sincerely,

Howard A. Tobin, M. D., F. A. C. S.

Dr. Howard Tobin of Abilene Texas is a cosmetic surgeon, and medical director of the Facial Plastic & Cosmetic Surgical Center in Abilene. He is a clinical assistant professor of surgery at the Texas Tech Medical School, and serves as an examiner for the American Board of Cosmetic Surgery. Dr. Tobin is also the Chairman of the Public Relations Committee of the American Academy of Cosmetic Surgery.

* *Plastic & Reconstructive Surgery, November 1982 p 600-604*

Although advertising can be abused in cosmetic surgery, just as it can be in any field, there is no question that advertising can educated the public as to what is available to them. It also can serve to provide choice for the consumer. This is especially important in the area of cosmetic surgery, since patients usually do not find their doctor through the more traditional referral patterns. In fact, many doctors are quite ignorant of what is available in cosmetic surgery since it is so often felt to be outside of the main stream of medicine.



April 14, 1989

Howard A. Tobin, M.D., F.A.C.A.
6300 Humana Plaza
Abilene, Texas 79606

Dear Dr. Tobin:

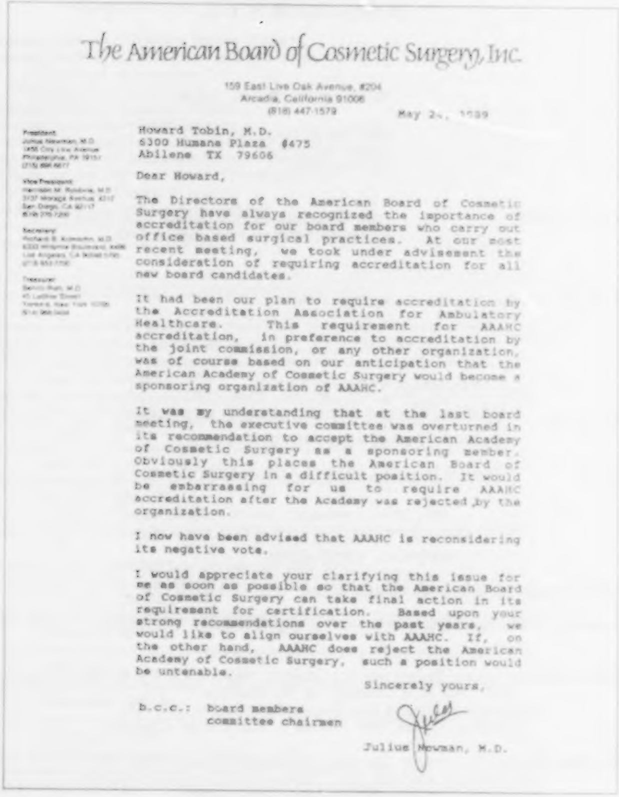
I could not be more pleased, I am amazed at the results of my surgery. You truly do beautiful work!

My letter has a twoflod purpose. I had breast implants 17 years ago, as you know, the results were less than desirable. I was suffering a lot of pain and the complication of the hardening was making it very difficult to do self examinations. I had been feeling a great deal of psychological stress for over a year, because of these problems.

I was aware of all the new techniques and improved implants, but I thought it was too late for me, I had had my implant surgery too early. Not until I saw your advertisement in the paper, in black and white, stating that you replaced unsatisfactory implants, did I know that this option was open to me. I made an appointment for a consultation with you before the day was over.

Dr. Tobin, I just want you to know how important it is for you to continue to keep the public informed on what is available to them, through your advertisements. It has certainly made a big difference in my life.

Sincerely,



The American Board of Cosmetic Surgery, Inc.

159 East Live Oak Avenue, #204
Arcadia, California 91006
(818) 447-1579

May 2[illegible], 1989

President

Vice President

Secretary

Treasurer

Howard Tobin, M.D.
6300 Humana Plaza #475
Abilene TX 79606

Dear Howard,

The Directors of the American Board of Cosmetic Surgery have always recognized the importance of accreditation for our board members who carry out office based surgical practices. At our most recent meeting, we took under advisement the consideration of requiring accreditation for all new board candidates.

It had been our plan to require accreditation by the Accreditation Association for Ambulatory Healthcare. This requirement for AAAHC accreditation, in preference to accreditation by the joint commission, or any other organization, was of course based on our anticipation that the American Academy of Cosmetic Surgery would become a sponsoring organization of AAAHC.

It was my understanding that at the last board meeting, the executive committee was overturned in its recommendation to accept the American Academy of Cosmetic Surgery as a sponsoring member. Obviously this places the American Board of Cosmetic Surgery in a difficult position. It would be embarrassing for us to require AAAHC accreditation after the Academy was rejected by the organization.

I now have been advised that AAAHC is reconsidering its negative vote.

I would appreciate your clarifying this issue for me as soon as possible so that the American Board of Cosmetic Surgery can take final action in its requirement for certification. Based upon your strong recommendations over the past years, we would like to align ourselves with AAAHC. If, on the other hand, AAAHC does reject the American Academy of Cosmetic Surgery, such a position would be untenable.

Sincerely yours,

b.c.c.: board members
committee chairmen

Julius Newman, M.D.

Letter from American Board of Cosmetic Surgery re: AAAHC application

CURRICULUM VITAE

Howard A. Tobin, M.D.

6300 Humana Plaza; Suite 475
Abilene, Texas 79606
(915) 695-3630

OCCUPATION: Cosmetic Surgeon, Medical Director, Facial Plastic & Cosmetic Surgical Center, Abilene, Texas.

DATE OF BIRTH: April 25, 1938

PREMEDICAL EDUCATION:

High School: Rutgers Preparatory School, New Brunswick, New Jersey, graduated 1956 (ranked second in graduating class).

College: Princeton University, graduated 1960 cum laude [illegible]ology B.A.

MEDICAL EDUCATION:

Medical College: Baylor Medical College,Houston, Texas - graduated 1964.

Internship: Medical-Surgical Internship, Univ. of Virginia Hospital , Charlottesville, Virginia, 1964-1965.

Residency: General Surgery, Baylor University College of Medicine Affiliated Residency Program, 1965 -1966, M. E. DeBakey, M. D. - Chairman.
Otolaryngology - Head & Neck Surgery, Baylor U. Col. Med. Affil. Residency Program, 1966 -1969. B. R. Alford, M. D. - Chairman.

Fellowship: Head and Neck Surgery, University of Cincinnati Medical College, 1971-1972, Donald A. Shumrick, M.D., Chairman. (also served as instructor in Department of Otolaryngology and Maxillofacial Surgery)

MILITARY SERVICE: Served as Chief of Otolaryngology Services at USAF Hospital, Dyess Air Force Base, Texas, July 1969-1971. Honorable Discharge - Rank: Major.

BOARD CERTIFICATION:

American Board of Cosmetic Surgery, Inc
American Board of Otolaryngology - Head & Neck Surgery

PROFESSIONAL SOCIETIES:

American Academy of Cosmetic Surgery - Fellow
American Academy of Facial Plastic and Reconstructive Surgery - Fellow
  & Member of the Founders' Club
American Academy of Otolaryngology - Head and Neck Surgery - Fellow
American College of Surgeons - Fellow
American Medical Association - Member
American Society for Head and Neck Surgery - Fellow
American Society of Lipo-Suction Surgery - Member
Cosmetic Surgical Society of Texas - Founding Fellow
Phi Beta Pi Medical Fraternity - Member
Society of Head and Neck Surgeons - Fellow
Taylor Haskell Jones County Medical Society - Member
Texas Medical Association - Member

PROFESSIONAL APPOINTMENTS:

Accreditation Association for Ambulatory Health Care, Inc. Board of Directors - 1984-
Accreditation Association for Ambulatory Health Care, Inc. Facility Surveyor - 1985-
Accreditation Association for Ambulatory Health Care, Inc. - Survery and Standards
  Committee Chairman 1989-
Accreditation Association for Ambulatory Health Care, Inc. - Executive Committee - 1989-
American Academy of Cosmetic Surgery - Division of Cosmetic Breast Surgery; Board of
  Directors - 1986-198
American Academy of Cosmetic Surgery; Ambulatory Surgery Committee, Chairman -
  1985-1987
American Academy of Cosmetic Surgery; Education & Research Foundation Board of
  Directors - 1987-1988
American Academy of Cosmetic Surgery - Finance Committee member, 1988-
American Academy of Cosmetic Surgery; Public Relations Committee Chairman - 1989-
  1991
American Academy of Cosmetic Surgery; Secretary 1987-1989
American Academy of Facial Plastic and Reconstructive Surgery; Ambulatory Surgery
  Committee, Chairman 1982-
American Academy of Facial Plastic and Reconstructive Surgery; Socioeconomic Committee
  Member - 1986-
American Academy of Facial Plastic and Reconstructive Surgery; Nominating Committee -
  1988-1989
American Academy of Otolaryngology - Head and Neck Surgery; Head and Neck Cancer
  Committee - 1982-86
American Academy of Otolaryngology - Head and Neck Surgery; Subcommittee on Quality
  Assurance - 1988-90
American Board of Cosmetic Surgery Examiner - 1985-
American Board of Cosmetic Surgery Fellowship Coordinator - 1986-1988
American College of Surgeons Goveronor's Committee on Alternate Health Care Systems -
  1987
American Journal of Cosmetic Surgery - Editorial Advisory Board - 1988-
American Society of Liposuction Surgery 1987 Advisory Board
Ethicon Facial Plastic Advisory Panel 1987-
Food & Drug Administration - U.S. Department of Health & Human Services - General
  Plastic & Surgery Devices Advisory Panel - participate in development of
  educational program for prospective breast imiplant patients - 1989
Humana Hospital - Abilene; Utilization review committee - 1986-
North American Physicians Insurance Risk Retention Group; Board of Directors, executive
  committee 1987-
Texas Society of Cosmetic Surgeons; Vice President & Executive Director - 1987-
Texas Tech University School of Medicine Clinical Assistant Professor of Surgery, 1987-

PROFESSIONAL HONORS:

American Medical Association - Physician's Recognition Award; 1969-present
American Academy of Otolaryngology - Head and Neck Surgery Honor Award, October, 1983
American Board of Cosmetic Surgery - Certificate of Appreciation - 1987
American Academy of Cosmetic Surgery - Best presentation at 1987 annual meeting: "Revision Mammaplasty with Replicon Prosthesis"
American Academy of Facaial Plastic & Reconstructive Surgery Honor Award for distinguished service, 1989

SCIENTIFIC PAPERS AND PRESENTATIONS

38 articles and textbook chapter accepted for publication in various journals and medical tesxtbooks, mostly related to cosmetic surgery or to office based ambulatory surgery. Dr. Tobin has presented lectures, courses or workshops at over 50 meetings since 1983.

APPROVED BY AMA HOUSE OF DELEGATES 6/20/89

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-89)

Introduced by:	Louis F. Alfano, M. D., Delegate American Society of Abdominal Surgeons
Subject:	Need for Standards for Truthful Medical Advertising
Referred to:	Reference Committee on Amendments to Constitution and Bylaws (Richard B. Tompkins, M. D., Chairman)

Whereas, The Federal Trade Commission has effectively barred the American Medical Association from establishing meaningful standards for medical advertising that is truthful, informative and not deceptive; and

Whereas, State and county medical societies are similarly barred from establishing or enforcing such standards with respect to their members; and

Whereas, State medical licensure authorities are similarly restricted; and

Whereas, The American public has been endangered by deceptive, untruthful medical advertising promising risk-free, pain-free out-patient treatment and surgery without loss of time from work, and results far beyond reasonable expectations; and

Whereas, Much of this treatment and surgery, particularly elective cosmetic procedures, is performed by physicians without specialized training in the procedures they perform and with inadequate facilities; and

Whereas, The Federal Trade Commission, while effectively barring private organizations from establishing and enforcing standards, does not exercise its authority to adopt and enforce reasonable standards for medical advertising; therefore be it

RESOLVED, That the American Medical Association request the Federal Trade Commission to conduct hearings, where interested parties may be heard, for the purpose of establishing Federal Trade Commission standards governing truthful, non-deceptive and non-misleading advertising.

Fiscal Note: $2,000

TESTIMONY OF
Peyton E. Weary, M.D.
and
Donald G. Langsley, M.D.
on behalf of
The American Board of Medical Specialties
at the hearings on
COSMETIC SURGERY
Presented to:
The Subcommittee on Regulation and Business Opportunities
of the
United States House of Representatives
June 28, 1989

Mr. Chairman, I am Dr. Peyton Weary, Professor and Chairman of the Department of Dermatology at the University of Virginia School of Medicine and President-Elect of the American Board of Medical Specialties (ABMS). With me is Dr. Donald G. Langsley, Executive Vice President of the ABMS. We are presenting this testimony on behalf of the American Board of Medical Specialties which is the umbrella organization of the 23 medical specialty certifying boards which have been approved and recognized by the Liaison Committee for Speicalty Boards (LCSB), the ABMS and the American Medical Association (AMA). These are the medical specialty certifying boards which are generally recognized throughout the American health care system. It is the responsibility of these boards to provide assurance to the public that a certified medical specialist is a physician who has successfully completed an approved educational program of three to seven or more years and who has passed an evaluation process which includes an examination designed to assess the knowledge as well as the skills and experience requisite to the provision of quality patient care in that specialty.

Certifying boards have been in existence since 1917 when the American Board of Ophthalmology was organized. By 1933 there were four boards and they joined with groups such as the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, the Federation of State Medical Boards and the National Board of Medical Examiners to establish the American Board of Medical Specialties (through its predecessor, the Advisory Board for Medical Specialties). The purpose of the ABMS was to improve medical care through the setting of professional standards and surveillance of medical qualifications. In 1934, the ABMS and the AMA joined forces to develop a system for approving and recognizing new boards and they organized the Liaison Committee for Specialty Boards (LCSB). By 1948 eighteen specialty boards had been approved. None were approved during the next twenty years but during the decade between 1969 and 1979, five additional boards were approved. The most recent action to approve a new board was taken in 1979 (Emergency Medicine) but there are presently two applications under review. The LCSB functions under a set of "Essentials for the Approval of Examining Boards in Medical Specialties" which set forth the criteria for and process for approval of new specialty boards. The criteria for approval include:

(1) Evidence that a new board signifies a new specialty based on major new concepts in medical science (not simply a technical skill or procedure).

(2) Evidence that a new board represents a distinct and well-defined field of medical practice based on substantial advancement in medical science and that the needed training must be sufficiently complex or extended that it is not feasible to include it in established training programs.

(3) Evidence that its diplomates have acquired capability in a stated area of medicine and demonstrate special knowledge in that field.

(4) A plan whereby graduate medical education programs (full time residency programs following awarding of the MD degree) may be accredited by the Accreditation Council for Graduate Medical Education (ACGME).

(5) Evidence that the proposed board has broad professional support in the specialty and that approval will promote and enhance recognition of a single standard of preparation for practice in each specialty.

(6) A detailed plan for evaluating individual candidates including the completion of approved training (at least three and up to seven years of full time residency) along with a written examination and for most of the specialties, an additional oral examination together with evidence of satisfactory performance during the residency and thereafter.

In addition, you should be aware that the ABMS has supported the concept of recertification and, in fact, 17 of the 23 boards have adopted the use of time-limited certificates so that to maintain certification, the physician must be recertified every seven to ten years.

In addition to the specialty certification process, accreditation procedures protect the public by the evaluation of education. State licensure boards offer the protection of a license to practice medicine and surgery. Those physicians who attend medical schools in the United States and Canada have the benefit of assurance of the high quality of the educational program by the accreditation activities of the Liaison Committee for Medical Education (LCME), which periodically inspects and reviews every medical school in these two nations. Those which do not meet the standards are placed on probation or have their approval withdrawn. In like fashion, residency training programs (including the first post-MD year which used to be called the "internship") are accredited by the Accreditation Council for Graduate Medical Education (ACGME), thus giving assurance of high quality specialty education. There is also accreditation of sponsors of continuing medical education (CME) by the Accreditation Council for Continuing Medical Education (ACCME).

We present this information to remind you that the physician certified by an ABMS-approved specialty board has completed medical education in an approved school and has completed accredited residency training of three to seven years as well as having passed an examination and evaluation process. If the physician-specialist is also a subspecialist, that indicates an additional one to three years of full time residency training and another examination process. Futhermore, as time moves on almost all specialists will have to demonstrate their competence in practice in order to be recertified. Though no system guarantees perfection, this method of certifying medical specialists offers assurance of high qualifications and competence.

Unhappily, however, the statement that a physician is "board certified" is not enough. There are at least 105 self-designated boards of which we know and there is no system for guaranteeing that such boards meet the high standards required for ABMS and AMA approval and recognition. In our country, anyone can organize a "board" and name it the "American Board of whatever". Those who organize such boards set their own standards. They may waive any required education and may waive any examination process. A few of these self-designated boards have high standards and require residency training plus an examination in a fashion similar to that of the ABMS member boards. We have encouraged them to consider application to the LCSB for recognition and approval. Most, however, do not seem to meet such standards. Our knowledge of their organizations, sponsors and systems is often scanty and in response to queries from various physicians, they only release brochures urging the respondent to apply and pay certain fees. In contrast, the organization, requirements and systems of the ABMS member boards are public knowledge.

This presents a serious dilemma to the American public which does not know the difference between certification by an ABMS-approved board and a self-designated board. To the average citizen the advertisement of being "board certified" carries with it an expected level of qualifications and competence which may not coincide with reality. If a physician is a member of the medical staff of a hospital accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and has privileges to practice in that hospital it generally indicates that the qualifications of the physician to claim board certification have been reviewed. However, many physicians confine their practice to their private offices or to unaccredited alternative sites. The average citizen who may have extensive and complex treatment, including surgery, in a private office could view the display of a "certificate" from a self-designated board or the advertisement of "board certified" as assurance of protection which is deceptive. We have tried to increase public awareness of this situation, but you will understand what a challenge it is to try to educate all of America about this complex process.

We are not advocates for medical specialists and prefer to consider ourselves as advocates for the public. We hope that you can find some solution which proposes that a physician represented to be a certified medical specialist is one who is certified by a Member Board of the American Board of Medical Specialties or the American Osteopathic Association. We would be pleased to offer any additional information or assistance you may wish in your deliberations of this complex issue.

For your information, we enclose a copy of the Essentials for the Approval of Examining Boards in Medical Specialties, two public information brochures which the ABMS has published and a list of the 105 self-designated boards.

AMERICAN BOARD OF MEDICAL SPECIALTIES
One Rotary Center, Suite 805 Evanston, Illinois 60201-4889 312/491-9091

Members
American Board of Allergy & Immunology
American Board of Anesthesiology
American Board of Colon & Rectal Surgery
American Board of Dermatology
American Board of Emergency Medicine
American Board of Family Practice
American Board of Internal Medicine
American Board of Neurological Surgery
American Board of Nuclear Medicine
American Board of Obstetrics & Gynecology
American Board of Ophthalmology
American Board of Orthopaedic Surgery
American Board of Otolaryngology
American Board of Pathology
American Board of Pediatrics
American Board of Physical Medicine
and Rehabilitation
American Board of Plastic Surgery
American Board of Preventive Medicine
American Board of Psychiatry & Neurology
American Board of Radiology
American Board of Surgery
American Board of Thoracic Surgery
American Board of Urology

Associate Members
American Hospital Association
Association of American Medical Colleges
Council of Medical Specialty Societies
Federation of State Medical Boards of U.S.
National Board of Medical Examiners

Public Members
Robert J. Blendon, Sc.D.
Renée C. Fox, Ph.D.

Officers/Executive
Committee 1988-89
Robert B. King, M.D.
President
Peyton E. Weary, M.D.
Vice President
Alexander J. Walt, M.D.
Treasurer
Roger Bolles, M.D.
Leo J. Dunn, M.D.
Donald T. Erwin, M.D.
Laurence Finberg, M.D.
Alan D. Perlmutter, M.D.
Paul R. Young, M.D.

Staff
Donald G. Langsley, M.D.
Executive Vice President
Barbara K. Kramer, Ph.D.
Director of Research
Alexis L. Rodgers
Director of Operations
Margaret F. Kruty
Coordinator of Publications

March 27, 1989

SELF-DESIGNATED BOARDS

Information exists in the ABMS files on the following self-designated boards. They are called "American Board of ________________" unless otherwise designated, and each purports to certify physicians.

Abdominal Surgeons
Acupuncture Medicine
Addictionology
Aesthetic Plastic Surgery
Alcoholism & Other Drug Dependencies (AMSAODD)
Algology (Chronic Pain)
Ambulatory Anesthesia
Anthroscopy
Arthroscopic Surgery
Bariatric Medicine
Bionic Psychology
Bloodless Medicine & Surgery
Cardiac Catheterization and Angiography
Chelation Therapy
Chemical Dependence
Clinical Chemistry
Clinical Ecology
Clinical Neurology
Clinical Neurophysiology
Clinical Neurosurgery
Clinical Nutrition
Clinical Orthopaedic Surgery
Clinical Pharmacology
Clinical Polysomnography
Clinical Psychiatry
Clinical Psychology
Clinical Toxicology
Cosmetic Plastic Surgery
Cosmetic Surgery
Council of Non-Board Certified Physicians
Critical Care in Medicine & Surgery
Disability Evaluating Physicians
Electrodiagnostic Medicine
Electroencephalography
Electromyography and Electrodiagnosis
Environmental Medicine
Epidemiology (College)
Facial Cosmetic Surgery
Facial Plastic Surgery
Forensic Psychiatry
Forensic Toxicology

Hand Surgery
Head, Facial & Neck Pain & TMJ Orthopedics
Health Physics
Homeotherapeutics
Hypnotic Anesthesiology, National Board for
Industrial Medicine & Surgery
Insurance Medicine
Int'l. Cosmetic & Plastic Facial Reconstr. Stds.
Interventional Radiology
Laser Surgery
Law in Medicine
Malpractice Physicians
Maxillofacial Surgeons
Medical Accreditation (American Federation for)
Medical Genetics
Medical Hypnosis
Medical Laboratory Immunology
Medical-Legal Analysis of Medicine & Surgery
Medical Legal & Workers Compensation Medicine & Surgery
Medical Legal Consultants
Medical Microbiology
Medical Preventics (Academy)
Medical Toxicology
Medical Psychotherapists
Microbiology (Medical Microbiology)
Military Medicine
Neurologic & Orthopaedic Dental Medicine & Surgery
Neurological & Orthopaedic Medicine
Neurological & Orthopaedic Surgery
Neurological Microsurgery
Neuro-Orthop. Dental Medicine & Surgery
Neuro-Orthop Electrodiagnosis
Neuro-Orthop. Laser Surgery
Neuro-Orthop. Psychiatry
Neuro-Orthop. Thor. Medicine/Surgery
Nutrition
Orthopaedic Microneurosurgery
Otorhinolaryngology
Pain Management (American Academy of)
Pain Management Specialties
Pain Medicine
Percutaneous Diskectomy
Plastic Esthetic Surgeons
Prison Medicine
Psychiatric Medicine
Psychiatry (American National Board of)
Psychoanlaysis (American Examining Board in)
Psychological Medicine (International)

List of Self-Designated Boards
March 27, 1989
Page 3

Quality Assurance and Utilization Review
Radiology and Medical Imaging
Rheumatologic Surgery
Rheumatological and Reconstructive Medicine
Ringside Medicine & Surgery
Skin Specialists
Spinal Cord Injury
Spinal Surgery
Sports Medicine
Sports Medicine/Surgery
Toxicology
Trauma Surgery
Traumatologic Medicine & Surgery
Tropical Medicine
Ultrasound Technology
Urologic Allied Health Professionals

Total - 105

The
American Board of Medical
Specialties

MEDICAL SPECIALTY CERTIFICATION and RELATED MATTERS

An Information Booklet
Not ABMS Official Policy

INTRODUCTION

Many young men and women come to medical school interested in a particular specialty. The medical student may begin school with the hope of becoming a pediatrician, a surgeon, a family practitioner or a specialist in some other field. Medical school experiences often change one's mind, and the would-be internist may become more interested in psychiatry. No matter how those interests develop or how decisions are made, the student often applies for graduate training (internship and/or residency) with little knowledge of the process of becoming certified as a specialist.

Terms such as licensure, certification, accreditation, specialty, subspecialty, recertification, boards, and residency review committees seem mystifying. Unfortunately, it is not unusual for a physician to be in the final years of specialty training before thinking about the requirements and qualifications necessary to obtain recognition as a medical specialist. This brochure is meant to organize information for the medical student, the house officer and others, and to list sources of further information. It may also be of use for highlighting the usefulness of specialty certification in improving the quality of medical care and the value of specialty certification to the medical student, resident, practicing physician and the general public.

DEFINITIONS

Residency describes the period of training in a specific medical specialty. It occurs after graduation from medical school and the length varies from three to seven years depending upon the specialty. It used to be common for graduates of medical school to spend a year of **internship** in a hospital in order to gain experience and to learn about taking responsibility for the care of a patient in the role of a physician.

The first graduate year of training following the completion of medical school and the awarding of the M.D. degree is now generally called the **PGY-1 Year,** though **Internship** has been the more traditional term. The "rotating internship" was abolished in 1975, but before that time nearly half of all medical school graduates took a rotating internship and the rest took internships sponsored by a single specialty.

After 1975, the rotating internship was replaced by the **Flexible** residency (one sponsored by several clinical departments). Currently, they are called **Transitional Year** programs. Transitional and Flexible residency years are organized and sponsored by institutions or several clinical departments, whereas the PGY-1 year that is part of a residency program in a given specialty is organized and sponsored by a single specialty department.

Residency Programs are programs of graduate medical education to train specialists. They are principally based in hospitals, though during a residency the physician may be assigned to clinics or other ambulatory centers (especially in the primary care specialties). Almost all physicians take a residency program to become a specialist. A 1979 Association of American Medical Colleges' survey found that 93% of graduating physicians planned to complete a residency program and become a certified specialist. Whereas, there were a total of 5,118 positions for residents in 1940, there were more than 62,000 resident positions in 1981 that were distributed among 4,588 programs.

Accreditation is a process that refers to residency programs. They must meet certain standards to gain approval. **Programs are accredited,** but **individual physicians are certified.** Residency programs are accredited by a **Residency Review Committee** for that particular specialty. The 24 Residency Review Committees are sponsored by the specialty boards, the specialty societies, and the American Medical Association (AMA). The accrediting process involves a review of certain written information, a site visit to the training program, and thoughtful consideration of the information by a Residency Review Committee. The **Accreditation Council for Graduate Medical Education (ACGME)** oversees the accreditation of training in all specialties.

Medical Schools are also accredited - by the **Liaision Committee on Medical Education (LCME),** a joint committee of the Association of American Medical Colleges (AAMC) and the AMA.

Matching is the process by which most medical students obtain an appointment for the PGY-1 Year and usually takes place through the **National Residency Matching Program (NRMP).** The NRMP receives rank order preferences from the students who apply and from the residency programs to which they have applied. The NRMP matches the highest ranked application of the student with the residency program that ranks that student high enough to fill a vacant position in the program. Medical students are advised by their schools on the procedures of the match, how to arrange for letters of recommendation and interviews, and how to complete applications for residency training programs. They obtain information about training programs from their faculty and from the *DIRECTORY OF RESIDENCY TRAINING PROGRAMS,* published by the AMA. The Directory lists all accredited residency programs, including the PGY-1 programs. Residency programs that include a PGY-1 year in their own specialty are called **Categorical** Programs.

Certification is the process of credentialing a specialist. After completion of residency training, the physician may decide to apply for certification. The time table for applying will vary with the particular specialty. Some specialties permit the application to be filed during the residency and some permit the first part of the certification exam to be taken during or shortly after the residency. Others may require a specific period of practice or experience before applying.

The 23 **Specialty Boards** grant certification when all requirements have been met. They have a major influence on graduate medical education since they set criteria that must be met for eligibility to take the certification exams. Each Board sets the minimum length of time for education in an accredited residency and, to some extent, determines the content of the training program since they determine the content of the certifying exam. If the applicant (called **"Candidate"**) meets the Board requirements, including passing the exam, he or she becomes a **Diplomate** in that specialty.

Specialty Societies are organizations of physicians involved in a given field of practice. Specialty societies represent the interests of practitioners. In most specialty societies, it is not necessary to be Board Certified to be eligible for membership.

Licensure is legal permission granted by a state government to take personal and unsupervised responsibility for the treatment of patients for the practice of medicine. In almost all states, at least one year of graduate medical education is required to secure a license. In some state as much as three years of training may be required. In addition, the applicant for licensure must pass an examination.

Certification by a specialty board enables the public to identify those practitioners who have met a standard of training and experience set well above the level required for licensure. Licensure is meant to establish the minimum competence required to protect the public health, safety and welfare. Certifying Boards, unlike state licensing boards, are national in scope, independent, and voluntary.

State Medical Boards carry on the licensure of physicians. Each state has its own Board with its own set of requirements. A license may be obtained by examination in that state or by reciprocity if the physician is licensed in another state, or by meeting the requirements of the **National Board of Medical Examiners**. A license is not always required during residency, though in some states it is necessary to have a license after the first year or two of training. All physicians must be licensed to practice whether they are certified or not. The State licensing Boards have organized their own umbrella organization, the **Federation of State Medical Boards.**

MEDICAL ORGANIZATIONS

The 24 major specialty societies, those equivalent to the Specialty Boards that are members of the ABMS, have established an umbrella organization to represent and serve them, the **Council of Medical Specialty Societies (CMSS).** The specialty societies are more involved in practice issues than the specialty boards (which consider their major responsibility the setting of standards for certification and the process for certification), but the societies are also interested in education and may serve as sponsors of the Residency Review Committees (RRCs) that accredit residency programs. Most specialists will join a specialty society and residents and medical students are encouraged to become involved early in their careers.

The **Association of American Medical Colleges (AAMC)** is sponsored by the medical schools, teaching hospitals and other educational groups.

The **American Hospital Association (AHA)** is organized by all hospitals, not just teaching hospitals, to represent them. There is also an **Association of Academic Health Centers (AAHC).**

The **American Medical Association (AMA)** is the largest medical organization and is composed of county and state medical societies along with representatives from specialty societies, hospital medical staff, and others. The AMA has long been interested in and involved with setting standards for and supporting medical education at all levels.

The **American Board of Medical Specialties (ABMS)** is the parent organization for the 23 recognized medical specialty boards responsible for administering certification examinations to physician specialists.

The **Accreditation Council for Graduate Medical Education (ACGME)** is organized under the sponsorship of five organizations: AAMC, ABMS, AHA, AMA, and CMSS. It is responsible for the accreditation of residency training programs and operates through the 24 Residency Review Committees (RRCs).The RRCs process the actual accreditation of residency programs, but the ACGME approves standards and deals with appeals and other administrative issues.

The **Joint Commission on Accreditation of Hospitals (JCAH)** is responsible for accrediting hospitals and is sponsored by the AMA, AHA, the American College of Physicians (ACP), the American College of Surgeons (ACS), and the American Dental Association (ADA).

The **Educational Commission for Foreign Medical Graduates (ECFMG)** screens graduates of foreign medical schools to verify their qualifications for admittance to residency training in U.S. programs. It does so by an examination of credentials, a test of knowledge of medical matters (the Foreign Medical Graduate Examination in the Medical Sciences, FMGEMS), and a test of facility in the English language. Those who pass these criteria are eligible to apply for residencies in the United States.

The **Accreditation Council for Continuing Medical Education (ACCME)** accredits sponsors of continuing medical education programs and is, itself, organized under the sponsorship of seven organizations: ABMS, AMA, AHA, AAMC, CMSS, AHME, and FSMB.

The **Council for Medical Affairs (CFMA)** serves as a forum in which the ABMS, AHA, AMA, AAMC, and CMSS can exchange information on matters related to medical education.

Medical students provide input to the system through organizations such as the **American Medical Student Association (AMSA)**, the **Office of Student Representatives (OSR)** of the AAMC, or the **Medical Student Section of the AMA**. Residents provide input through the **House Staff Section of the AMA** and through specialty societies of which they are members.

If all of this sounds complicated, it is. The multiple organizations associated with medical education are all part of the voluntary effort of the profession to assure quality medical care for the public.

THE SIGNIFICANCE OF CERTIFICATION IN THE MEDICAL SPECIALTIES

From its inception, medical specialty certification in the United States has been a voluntary procedure. Since the establishment of the first nationally recognized medical specialty board in 1917, physicians have elected to seek formal recognition of their qualifications in chosen specialty fields by presenting themselves for examination before specialty boards comprised of their professional peers. Definitions of each of the specialties and of the educational and other requirements leading to eligibility for board certification have been developed by consensus within the medical profession and, to date, the certification of a medical specialist has remained separate and distinct from licensure of professionals qualified to practice medicine by civil authorities.

SUBSPECIALTY CERTIFICATION

There is no requirement that a diplomate in a recognized specialty hold special certification in a subspecialty of that field in order to be considered qualified to include aspects of that subspecialty within a specialty practice. Certification in a subspecialty field is of significance to physicians preparing for careers in teaching, research or practice restricted to that field. Such special certification is a recognition of exceptional expertise and experience and has not been created to justify a differential fee schedule nor to confer other professional advantages over other diplomates not so certified.

Physicians wishing to voluntarily limit their practice to the use of special devices and techniques or methodologies are free to do so. If they wish to have specialty board certification, it should be within one of the specialties that includes the use of the related device, technique, or methodology, along with the more basic body of knowledge that is applied through their use.

Approval of a new area for special certification, sometimes identified as subspecialty certification or as certification of special qualifications, signifies that there has been a thorough and critical review of the proposal by the ABMS Committee on Certification, Subcertification and Recertification (COCERT), by the Executive Committee, and by the full Membership. This critical review presupposes that such approval is accompanied by assurances from educational institutions to provide training in such areas.

NATURE AND FUNCTION OF SPECIALTY BOARDS

The primary objective of specialty boards is improvement in the quality of medical education and medical care.

The primary function of each of the specialty boards is to evaluate candidates in its field who appear voluntarily for examination and to certify as diplomates those who are qualified. To accomplish this function, specialty boards determine if candidates have received adequate preparation in accordance with established educational standards; they provide comprehensive examinations to evaluate such candidates, and they certify physicians who have satisfied the requirements.

In collaboration with other organizations and agencies concerned, the approved specialty boards assist in improving the quality of medical education by elevating the standards of graduate medical education and approving facilities for specialty training.

Each individual specialty board is composed of specialists qualified in the particular field represented by that board. Their members are derived from the several national specialty organizations in related fields and the AMA. They endeavor to maintain appropriate representation of specialists on the board according to geographic distribution, type of practice and academic relationships, qualification in the appropriate subspecialties, and demonstrated motivation and ability to assist in the evaluation procedures leading to certification.

INFORMATION ABOUT SPECIFIC SPECIALTIES

Each specialty has different requirements for completion of its residency programs and for admission to the examination for certification. Medical students and residents are encouraged to learn about the requirements for certification in the specialty of their choice **before** beginning training in that specialty and to keep abreast of possible changes in the requirements that may be effected during their training years. That information is summarized in the *Directory of Residency Training Programs* published annually by the AMA. That volume publishes the requirements for accreditation of residency programs in each specialty and the requirements of each specialty board for certification. However, because these requirements may change, and because not all subspecialties are listed in the Directory, it may be advisable to communicate directly with the specialty board to obtain the most recent information. Each board publishes an informational brochure. The addresses of the 23 medical specialty boards follow:

ALLERGY AND IMMUNOLOGY
American Board of Allergy and Immunology
University City Science Center
3624 Market Street
Philadelphia, PA 19104
(215) 349-9466

ANESTHESIOLOGY
American Board of Anesthesiology
100 Constitution Plaza
Hartford, CT 06103
(203) 522-9857

COLON & RECTAL SURGERY
American Board of Colon and Rectal Surgery
615 Griswold, Suite 1717
Detroit, MI 48226
(313) 961-7880

DERMATOLOGY
American Board of Dermatology
Henry Ford Hospital
Detroit, MI 48202
(313) 876-2178

EMERGENCY MEDICINE
American Board of Emergency Medicine
200 Woodland Pass, Suite D
East Lansing, MI 48823
(517) 332-4800

FAMILY PRACTICE
American Board of Family Practice
2228 Young Drive
Lexington, KY 40505
(606) 269-5626

INTERNAL MEDICINE
American Board of Internal Medicine
University City Science Center
3624 Market Street
Philadelphia, PA 19104
(215) 243-1500

NEUROLOGICAL SURGERY
American Board of Neurological Surgery
P.O. Box 4056
Chapel Hill, NC 27515-4056
(919) 966-3047

NUCLEAR MEDICINE
American Board of Nuclear Medicine
900 Veteran Avenue, Room 12-200
Los Angeles, CA 90024
(213) 825-6787

OBSTETRICS & GYNECOLOGY
American Board of Obstetrics & Gynecology
4225 Roosevelt Way, N.E., Suite 305
Seattle, WA 98105
(206) 547-4884

OPHTHALMOLOGY
American Board of Ophthalmology
111 Presidential Boulevard, Suite 241
Bala Cynwyd, PA 19004
(215) 664-1175

ORTHOPAEDIC SURGERY
American Board of Orthopaedic Surgery
737 North Michigan Avenue, Suite 1150
Chicago, IL 60611
(312) 664-9444

OTOLARYNGOLOGY
American Board of Otolaryngology
5615 Kirby Drive, Suite 936
Houston, TX 77005
(713) 528-6200

PATHOLOGY
American Board of Pathology
5401 West Kennedy Boulevard
PO Box 25915
Tampa, FL 33622
(813) 286-2444

PEDIATRICS
American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514
(919) 929-0461

PHYSICAL MEDICINE AND REHABILITATION
American Board of Physical Medicine and Rehabilitation
Suite 674, Norwest Center
21 First Street, S.W.
Rochester, MN 55902
(507) 282-1776

PLASTIC SURGERY
American Board of Plastic Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103
(215) 568-4000

PREVENTIVE MEDICINE
American Board of Preventive Medicine
Department of Community Medicine
Wright State University School of Medicine
PO Box 927
Dayton, OH 45401
(513) 278-6915

PSYCHIATRY AND NEUROLOGY
American Board of Psychiatry & Neurology
500 Lake Cook Rd., #335
Deerfield, IL 60015
(312) 945-7900

RADIOLOGY
American Board of Radiology
300 Park, Suite 440
Birmingham, MI 48009
(313) 645-0600

SURGERY
American Board of Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103
(215) 568-4000

THORACIC SURGERY
American Board of Thoracic Surgery
One Rotary Center, Suite 803
Evanston, IL 60201
(312) 475-1520

UROLOGY
American Board of Urology
Norwest Center, Suite 520
21 First Street, S.W.
Rochester, MN 55902
(507) 282-6500

PUBLICATIONS FROM THE ABMS:

ABMS Compendium of Certified Medical Specialists
Evaluation of Noncognitive Skills
Evaluating the Skills of Medical Specialists
Oral Examinations in Medical Specialty Board Certification
Legal Aspects of Certification and Accreditation
Computer Applications in the Evaluation of Physician Competence
The Residency Director's Role in Specialty Certification
Trends in Specialization: Tomorrow's Medicine
Hospital Privileges and Specialty Medicine
How to Evaluate Residents
Recertification for Medical Specialists
How to Select Residents

Contact the ABMS office for further information.

IF WE CAN BE OF FURTHER HELP WRITE TO
American Board of Medical Specialties
One Rotary Center, Suite 805
Evanston, IL 60201 Phone (312) 491-9091

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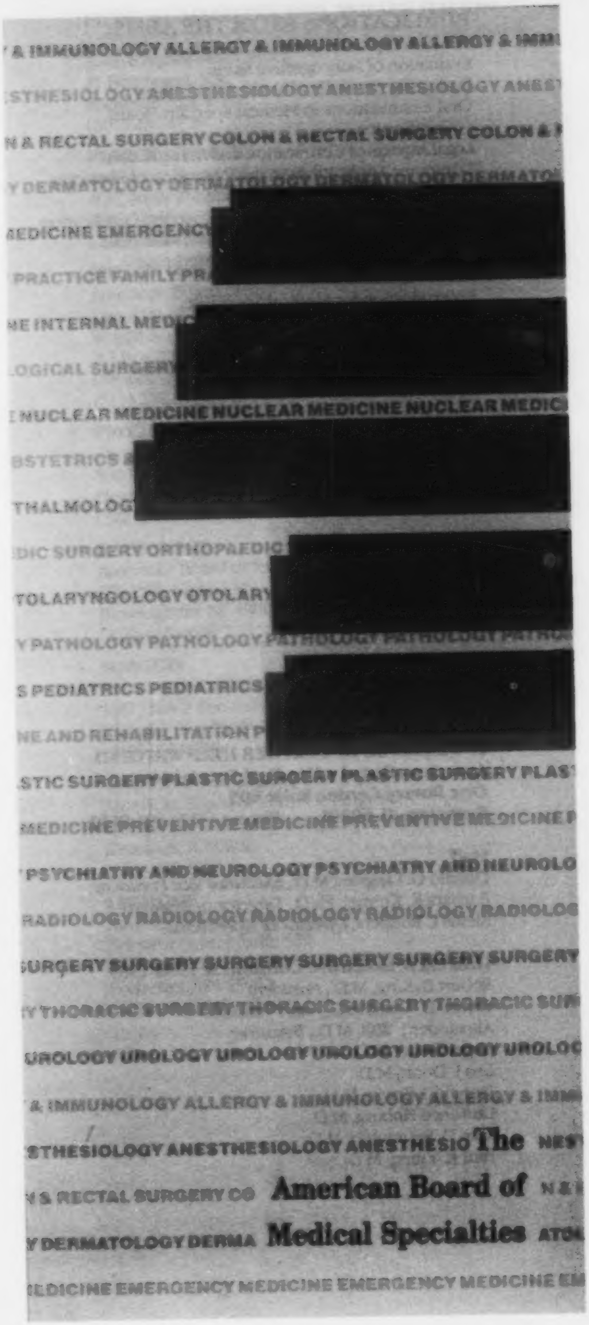

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YOU

Allergist/Immunologist
Anesthesiologist
Colon & Rectal Surgeon
Dermatologist
Emergency Physician
Family Physician
Internist
Neurological Surgeon
Neurologist
Nuclear Medicine Physician
Obstetrician & Gynecologist
Ophthalmologist
Orthopaedic Surgeon
Otolaryngologist
Pathologist
Pediatrician
Physical Medicine & Rehabilitation Physician
Plastic Surgeon
Preventive Medicine Physician
Psychiatrist
Radiologist
Surgeon
Thoracic Surgeon
Urologist

**The
American Board of
Medical Specialties**

One Rotary Center
Suite 805
Evanston, IL 60201
312/491-9091

ABMS APPROVED SPECIALTIES AND SUBSPECIALTIES
(Effective March, 1989)

Specialty Certificates	**Subspecialty Certificates**
Allergy & Immunology	Diagnostic Laboratory Immunology
Anesthesiology	Critical Care Medicine
Colon & Rectal Surgery	
Dermatology	Dermatopathology Dermatological Immunology/Diagnostic Laboratory Immunology
Emergency Medicine	
Family Practice	Geriatric Medicine
Internal Medicine	Cardiac Electrophysiology Cardiovascular Disease Critical Care Medicine Diagnostic Laboratory Immunology Endocrinology & Metabolism Gastroenterology Geriatric Medicine Hematology Infectious Disease Medical Oncology Nephrology Pulmonary Disease Rheumatology
Neurological Surgery	Critical Care Medicine
Nuclear Medicine	Nuclear Radiology (with ABRadiology) Radioisotopic Pathology (with ABPathology)
Obstetrics & Gynecology	Critical Care Medicine Gynecologic Oncology Maternal & Fetal Medicine Reproductive Endocrinology
Ophthalmology	
Orthopaedic Surgery	Hand Surgery
Otolaryngology	
Anatomic & Clinical Pathology	Blood Banking/Transfusion Medicine Chemical Pathology
Anatomic Pathology	Cytopathology
Clinical Pathology	Dermatopathology Forensic Pathology Hematology Immunopathology Medical Microbiology Neuropathology Radioisotopic Pathology
Pediatrics	Diagnostic Laboratory Immunology Pediatric Cadiology Pediatric Critical Care Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Nephrology Pediatric Pulmonology Neonat Perinatal Medicine
Physical Medicine and Rehabilitation	
Plastic Surgery	Hand Surgery
Aerospace Medicine	
Occupational Medicine	
Public Health & General Preventive Medicine	
Psychiatry	Child Psychiatry
Neurology	
Neurology with Special Qualifications in Child Neurology	
Radiology	Nuclear Radiology
Diagnostic Radiology	
Radiation Oncology	
Radiological Physics	
Surgery	Hand Surgery Pediatric Surgery Surgical Critical Care General Vascular Surgery
Thoracic Surgery	
Urology	

INTRODUCTION

Everyone knows what a "medical doctor" is—a physician who has had years of training to understand the diagnosis, treatment and prevention of disease. The basic training of a physician **specialist** includes four years of premedical education in a college or university, four years of medical school, and after receiving the M.D. degree, at least three years of specialty training under supervision (called a "residency"). Training in various **subspecialties** within the general specialties of internal medicine, obstetrics & gynecology, pathology, pediatrics, and surgery can take two to three years longer.

The process most widely used by physicians to tell whether and why you are sick is to ask you and/or your family members questions about your health and your past medical history. This process, called "taking a history," is usually followed by an appropriate examination of your body (a "physical examination") to determine how well it is functioning and whether there are signs of disease. Doctors also use a variety of tests such as x-rays, other imaging techniques, and additional procedures to evaluate your health and identify any diseases or other health problems which may be present. Some of these diagnostic procedures (e.g., cardiac catheterization, CAT scans, biopsy of body tissues) are very complicated. They call for many years of training in order to use them safely and accurately.

Then the doctor will recommend what treatment is needed, if any. Treatment may involve surgery (there are many types of surgical specialists), medication, or other complex procedures.

The complexity of the body's structrure and the way it functions call for high levels of skill in understanding body systems and in knowing the effect that each system has on the whole, in health and in disease. That is why, today, most physicians choose to specialize.

Specialists are doctors who concentrate on certain body systems, specific age groups, or on complex scientific techniques developed to diagnose or treat certain types of disorders. Specialties in medicine developed because of the rapidly expanding body of knowledge about health and illness and the constantly evolving new treatment techniques for disease. Today, no one doctor can hope to master the total field of medical knowledge or maintain skills in all diagnostic tests, treatments, and procedures.

A subspecialist is a physician who has completed training in a general medical specialty and then takes additional training in a more specific sub-area of that specialty called a subspecialty. This training increases the depth of knowledge of the specialist in that particular field. For example, cardiology is a subspecialty of internal medicine; pediatric surgery is a subspecialty of surgery; and child psychiatry is a subspecialty of psychiatry. The training of a subspecialist within a specialty requires an additional one or more years of full-time education in a program called a "fellowship."

Training of a Specialist: The training of a specialist begins after the doctor has received the M.D. degree from a medical school, in what is called a residency. Resident physicians dedicate themselves for three to seven years to full-time experience in a hospital or ambulatory care setting, caring for patients under the supervision of experienced teaching specialists. Educational conferences and research experience are also part of that training. A doctor in training to be a specialist is called a "resident," although the first year of residency used to be called an "internship."

In each state, the privilege to practice medicine is governed by state law and is not designed to recognize the knowledge and skills of a trained specialist. The physician is licensed to practice general medicine and surgery by a State Board of Medical Examiners after passing a licensure examination. Each state has its own examining procedure to license physicians, and this board sets the general standards for all physicians.

Who Credentials a Specialist and/or Subspecialist? Specialty boards certify physicians as having met certain published standards. There are 23 specialty boards that are recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA). All of the specialties and subspecialties recognized by the ABMS and the AMA are listed in the brief descriptions that follow. Remember, a subspecialist first must be trained and certified as a specialist.

In order to be certified as a medical specialist by one of these recognized boards, a physician must complete certain requirements. Generally, these include:

(1) Completion of a course of study leading to the M.D. or D.O. degr in a recognized school of medicine.

(2) Completion of three to seven years of full-time training in a accredited residency program designed to train specialists in th field.

(3) Some specialty boards require assessments of individual performance and competence from the residency training direc or from the chief of service in the hospital where the special has practiced.

(4) Most specialty boards require that the person who seeks certification have an unrestricted license to practice medicine i order to take the certification examination.

(5) Some boards require that the doctor have a period of experience in full-time practice in the specialty prior to examination for certification—usually two years following training.

(6) Finally, each candidate for certification must pass a written examination given by the specialty board. Sixteen of the 23 specialty boards also require an oral examination conducted senior specialists in that field. Candidates who have passed exams and other requirements are then given the status of "Diplomate" and are certified as specialists. A similar process i followed for specialists who want to become subspecialists.

Some boards issue certificates for a limited period of time, usually seven to ten years. In order to retain certification, diplomates of those boards must become "recertified," and must periodically go through an additional process involving continuing education in the specialty, review of credentials and further examination. Some boards that may not require recertification have provided voluntary recertification with similar requirements.

How To Determine If a Physician Is a Certified Specialist or Subspecialist: Certified specialists are listed in directories published by the American Board of Medical Specialties (ABMS). These include individual directories for each specialty and also the **ABMS COMPENDIUM OF CERTIFIED MEDICAL SPECIALISTS**. The **ABMS COMPENDIUM** can be found in most public libraries, hospital libraries and medical libraries. Directories are also available in university libraries. Alternatively, you could ask for that information from your county medical society, or from the American Board of Medical Specialties (see address and phone number in this brochure), or from a particular specialty board (see the list of specialty boards in this brochure).

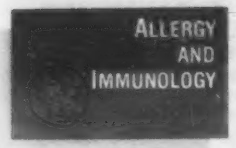
In addition, almost all board certified specialists are members of their medical specialty societies. These societies are dedicated to furthering standards, practice and professional and public education within individual medical specialities. Some, such as the American College of Surgeons and The American College of Obstetricians and Gynecologists, require board certification for full membership. A physician who has attained full membership is called a "Fellow" of the society and is entitled to use this designation in all formal communications, such as certificates, publications, business cards, stationery and signage. Thus, "John Doe, MD, FACS" (Fellow of the American College of Surgeons) is in all likelihood a board certified surgeon. Similarly, FAAP (Fellow of the American Academy of Pediatrics) or FAAD (Fellow of the American Academy of Dermatology) following the MD or DO in a physician's title would be likely to indicate board certification in those specialties.

The Purpose of Certification*

The intent of the certification process, as defined by the Member Boards of the American Board of Medical Specialties, is to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process designed to assess the knowledge, experience and skills requisite to the provision of high quality patient care in that specialty.

*Approved by the ABMS Assembly, 3/19/87

DESCRIPTION OF RECOGNIZED SPECIALTIES AND SUBSPECIALTIES



ALLERGY AND IMMUNOLOGY

An allergist-immunologist is a certified internist or pediatrician expert in the evaluation, physical and laboratory diagnosis, and management of disorders potentially involving the immune system. Selected examples of such conditions include asthma, anaphylaxis, rhinitis, eczema, urticaria, and adverse reactions to drugs, foods, and insect stings as well as immune deficiency diseases (both acquired and congenital), defects in host defense, and problems related to autoimmune disease, organ transplantation or malignancies of the immune system. The scope of this specialty is ever-widening as our understanding of the immune system develops. Selected experts may receive special certification in "Diagnostic Laboratory Immunology" after additional training in the various laboratory procedures required to analyze both the function and malfunction of the immune system.

ANESTHESIOLOGY

The anesthesiologist is a physician-specialist who, following medical school graduation and at least four years of postgraduate training, has the principal task of providing pain relief and maintenance, or restoration, of a stable condition during an operation, an obstetric or diagnostic procedure. The anesthesiologist assesses the risk of the patient undergoing surgery and optimizes the patient's condition prior to, during, and after surgery. Anesthesiologists diagnose and treat acute and long-standing pain problems. Anesthesiologists diagnose and treat patients who have critical illnesses or are severely injured. Anesthesiologists direct resuscitation in the care of patients with cardiac or respiratory emergencies including the provision of artificial ventilation. They also supervise and teach others involved in anesthesia, respiratory and intensive care. Anesthesiologists may specialize in Critical Care Medicine as practiced in critical care and intensive care units, post-anesthesia recovery rooms, and other settings.

Critical Care Medicine: The anesthesiologist who specializes in Critical Care Medicine is a physician who after completion of anesthesiology training must receive additional training in critical care because the requisite knowledge and skills extend beyond anesthesiology training and cross traditional specialty lines. The primary work place is an intensive or critical care unit. Anesthesiologists trained in critical care are qualified to diagnose, treat and support patients with multiple organ system dysfunction. In addition, they may have administrative responsibilities for intensive care units and may participate in the training and medical direction of essential health care professionals such as nurses and respiratory therapists. The critical care anesthesiologist, in addition to providing direct patient care, may also facilitate and coordinate patient care among the primary physician, the critical care staff, and other specialists.

COLON AND RECTAL SURGERY

A colon and rectal surgeon is a fully trained general surgeon who has had additional training in the diagnosis and treatment of diseases of the intestinal tract, rectum and anus. These include such anal conditions as hemorrhoids, fissures, and fistulas, and such colon and rectal diseases as polyps, cancer, colitis and diverticulitis.

DERMATOLOGY

A dermatologist is a physician concerned with the prevention, diagnosis, and treatment of benign and malignant disorders of the skin and related tissues of the mouth, external genitalia, hair and nails. The dermatologist also diagnoses and treats a number of diseases transmitted through sexual activity. Dermatologists use many diagnostic procedures including microscopic and microbiologic examination of the skin and its secretions. Treatment methods used by the dermatologist include externally applied, injected and internal medications, selected x-ray and ultraviolet light therapy, and a range of surgical procedures using instruments including the scalpel, surgical curette, electrosurgical unit, freezing surgical unit, and laser.

With this background and knowledge, the dermatologist is singularly qualified to advise on the care of normal skin, to prescribe measures to maintain the skin in a state of health, to make accurate diagnoses and administer treatment for all skin diseases and the skin manifestations of internal diseases and sexually-transmitted diseases. In addition, the dermatologist has had training and experience in the management of skin cancers, moles, and other tumors of the skin and in the use of the various techniques for the correction of cosmetic defects of the skin. Patients seeking a dermatologist ordinarily may come directly or be referred by another physician.

EMERGENCY MEDICINE

Emergency Medicine is the medical specialty that focuses on the immediate decision making and action necessary to prevent death or any further disability. It is primarily hospital emergency department based, but with extensive prehospital responsibilities for emergency medical systems.

The emergency physician provides immediate initial recognition, evaluation, care and disposition of a generally undifferentiated population of patients in response to acute illness and injury. The care provided by the emergency physician is episodic in nature and involves a full spectrum of physical and behavioral conditions.

FAMILY PRACTICE

Family Practice is the medical specialty which is concerned with the total health care of the individual and the family. It is the specialty in breadth which integrates the biological, clinical and behavioral sciences. The scope of family practice is not limited by age, sex, organ system or disease entity.

INTERNAL MEDICINE

A general internist is a physician who provides scientifically based, empathic care for the nonsurgical illnesses of adolescents and adults. This care tends to be characterized by a mutual personal commitment between doctor and patient, by stability over time, by substantial breadth, and by an appropriate attention to elements of human support, sensitivity, and concern. It is marked by technical sophistication and major professional expertise. The general internist provides continuing, comprehensive care for common and complex multisystem illnesses in the ambulatory care as well as the hospital setting. The general internist also functions as a consultant to other specialists and is competent to handle critically ill patients and nonsurgical disorders in adolescents and adults seeking aid in the emergency room setting. Well-trained internists are unique in their ability to deliver with broad competence primary, secondary, and tertiary care.

Internists may subspecialize in:

Cardiovascular Medicine: Cardiologists subspecialize in diseases of the heart, lungs, and blood vessels and manage complex cardiac conditions such as heart attacks and life-threatening abnormal heart beat rhythms, in settings such as the coronary care unit of a hospital. They often perform complicated diagnostic procedures such as cardiac catheterizations.

Critical Care Medicine: The internist-intensivist subspecializes in managing life-threatening acute disorders in intensive care units and other settings. Shock, coma, heart failure, respiratory arrest, drug overdoses, massive bleeding, diabetic acidosis, and kidney shutdown are examples of conditions requiring critical care by internists.

Diagnostic Laboratory Immunology: This is a subspecialty field in which laboratory tests and complex procedures are used to diagnose and treat disorders characterized by defective responses of the body's immune systems.

Endocrinology: The endocrinologist concentrates on disorders of the internal (endocrine) glands such as the thyroid and adrenal glands. Endocrinology also deals with disorders such as diabetes, metabolic and nutritional disorders, pituitary diseases, and menstrual and sexual problems.

Gastroenterology: The subspecialty of the digestive organs involves the stomach, bowels, liver, gallbladder, and related organs. The gastroenterologist treats conditions such as abdominal pain, ulcers, diarrhea, cancer, and jaundice, and consults with surgeons when abdominal operations are indicated. Gastroenterologists visualize the hollow organs through lighted endoscopes, and through these flexible tubes can biopsy lining tissues and remove small polyps.

Geriatric Medicine: All internists and subspecialists in internal medicine are skilled in the health needs of the elderly. Special skills in recognizing the altered presentation of illnesses, dealing with multi-system organ involvement, handling special drug interactions, utilizing resources such as nursing homes and community social services, and assisting with particular ethical issues in the care of the elderly can be obtained by additional training. Geriatric Medicine is not regarded as a subspecialty, but rather as an added competence in trained internists.

Hematology: Hematologists subspecialize in diseases of the blood, spleen, and lymph glands. They treat conditions such as anemia, clotting disorders, sickle cell disease, hemophilia, leukemia, and lymphoma, and may perform special types of transfusions and biopsy the bone marrow for analysis.

Infectious Disease: These subspecialists deal with infectious diseases of all types and in all organs. Conditions requiring selective use of antibiotics call for this special skill. Patients with fevers which have not been explained are often diagnosed and treated by these subspecialists.

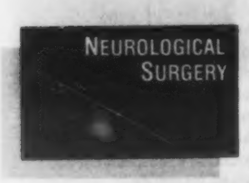
Medical Oncology: The medical oncologist specializes in the diagnosis and treatment of all types of cancer and other benign and malignant tumors. These subspecialists also decide on and administer chemotherapy for malignancy as well as consult with surgeons and radiotherapists on treatment for cancer.

Nephrology: The nephrologist is concerned with disorders of the kidney, hypertension, fluid and mineral balance, dialysis of body wastes when the kidneys do not function, and consultation with surgeons about kidney transplantation.

Pulmonary Diseases: Pulmonary Disease is the subspecialty concerned with diseases of the lungs and other chest tissues. The pulmonologist diagnoses and treats pneumonia, cancer, occupational diseases, bronchitis, emphysema, and other complex disorders of the lungs. Pulmonologists test lung functions in many ways, endoscope the bronchial airways, and prescribe and monitor mechanical assistance to ventilation. Many pulmonary disease experts supervise critical care units.

Rheumatology: The rheumatologist is concerned with diseases of joints, muscle, bones, and tendons. The rheumatologist diagnoses and treats arthritis, various types of back pain, muscle strains, common athletic injuries, and rare diseases of the connective tissue and arteries in many body systems called "collagen" diseases. He may work closely with other specialists such as physiatrists and orthopaedic surgeons.

Allergy & Immunology: The subspecialty of allergy and immunology is represented by a conjoint board of the American Board of Internal Medicine and the American Board of Pediatrics, called the American Board of Allergy and Immunology. See separate section.



NEUROLOGICAL SURGERY

Neurological Surgery is a discipline of medicine and that specialty of surgery which deals with the diagnosis, evaluation and treatment of disorders of the central, peripheral and autonomic nervous systems, including their supporting structures and vascular supply; and the evaluation and treatment of pathological processes which modify function or activity of the nervous system, including the hypophysis. The Neurological Surgeon is a specialist involved in the operative and non-operative management, diagnosis, evaluation, treatment, critical care and rehabilitation of patients with disorders of the nervous system.

NEUROLOGY

A neurologist is a physician concerned with the diagnosis and treatment of all categories of disease involving the central, peripheral and autonomic nervous systems, including their coverings, blood vessels, and all effector tissues, such as muscle. For these diseases he/she is often the principal physician and may render all levels of care commensurate with his/her training. He/she should have completed training in an accredited training program and may be certified through examination by the American Board of Psychiatry and Neurology, in Neurology or in Neurology with Special Qualifications in Child Neurology.

NUCLEAR MEDICINE

Nuclear medicine is the medical specialty that employs the nuclear properties of radioactive and stable nuclides in diagnosis, therapy and research. These properties are used to evaluate metabolic, physiologic, and pathologic conditions in both the clinical and laboratory setting.

A specialist in nuclear medicine is a physician who has been awarded a medical degree from an approved medical or osteopathic school, has satisfactorily completed two or more years of residency training in a general medical specialty and two additional years of nuclear medicine residency in accredited residency programs. He has satisfactorily passed a rigorous written examination encompassing the diagnostic and therapeutic uses of radioactive materials and in the related physical and biological sciences.

The professional competence of nuclear medicine physicians is in the diagnostic and therapeutic uses of radionuclides including: radioimmunoassay; therapy with radioisotopically labelled antibodies; positron emission tomography (PET); and single-proton emission computerized tomography (SPECT). Additionally, the nuclear medicine physician has special knowledge in the biologic effects of radiation exposure; the principles of radiation safety and protection; the management of patients who have been exposed to ionizing radiation; and special knowledge in the physical sciences encompassing the fundamentals of nuclear physics and nuclear magnetic resonance; the principles and operation of radiation detection and nuclear imaging instrumentation systems; statistics and fundamentals of computer sciences.

The nuclear medicine specialist serves as a consultant to physicians, obtaining pertinent information from patients as necessary by means of history and physical examination and selecting and carrying out appropriate diagnostic or therapeutic uses of radionuclides.

The nuclear medicine physician has broad knowledge and experience in medicine and is capable of extending the scope of nuclear medicine as the specialty evolves and expands.

OBSTETRICS AND GYNECOLOGY

Obstetrician-Gynecologists are physicians who, by virtue of satisfactory completion of a defined course of graduate medical education and appropriate certification, possess special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders, such that it distinguishes them from other physicians and enables them to serve as consultants to other physicians and as primary physicians for women.

Over the years of practice, each obstetrician-gynecologist builds on this broad base of knowledge and skills and may develop a unique type of practice and changing professional focus. Such diversity contributes to high quality health care for women.

A specialist in Obstetrics and Gynecology may subspecialize in:

Gynecologic Oncology: A gynecologic oncologist is a specialist in obstetrics and gynecology who, by virtue of education and training, is prepared to provide consultation on, and comprehensive management of, patients with gynecologic cancer and whose activity includes the practice of gynecologic oncology in an institutional setting wherein all effective forms of cancer therapy are available. Comprehensive management should include those diagnostic and therapeutic procedures necessary for the total care of the patient with gynecologic cancer or complications resulting therefrom.

Maternal-Fetal Medicine: A specialist in maternal-fetal medicine is a specialist in obstetrics and gynecology who, by virtue of additional education, is prepared to care for or provide consultation on patients with complications of pregnancy. This requires advanced knowledge in the obstetrical, medical and surgical complications of pregnancy and their effect on both the mother and the fetus. It also requires expertise in the most current diagnostic and treatment modalities used in the care of patients with high-risk pregnancies. Advanced knowledge of newborn adaptation is also necessary to insure a continuum of excellence in care from the fetal to newborn periods.

Reproductive Endocrinology: A reproductive endocrinologist is a specialist in obstetrics and gynecology who has been appropriately trained and is capable of managing complex problems relating to reproductive endocrinology and infertility, and whose professional activity involves the practice of reproductive endocrinology in an institutional setting wherein essential diagnostic and therapeutic facilities are being utilized appropriately.

OPHTHALMOLOGY

An ophthalmologist is a physician who has been awarded a medical degree from an accredited medical or osteopathic school, who has had at least one year of general medical post-graduate (internship) training in an accredited program and who has subsequently satisfactorily completed three or more additional years of post-graduate medical and surgical training in an accredited ophthalmology residency training program. Upon completion of training, Board certified ophthalmologists have passed the Written and Oral Examinations of the American Board of Ophthalmology.

Ophthalmologists have the knowledge and professional skills needed to provide comprehensive eye and vision care. They are the only practitioners medically trained to diagnose, monitor and medically or surgically treat all eyelid and orbital problems affecting the eye and visual pathways and to diagnose, monitor and treat all eye and visual disorders. In so doing, they often prescribe vision services (glasses and contact lenses). The ophthalmologist also serves as a consultant to physicians and other professionals.

ORTHOPAEDIC SURGERY

Orthopaedic Surgery is the medical specialty that includes the preservation, investigation and restoration of the form and function of the extremities, spine and associated structures by medical, surgical and physical means.

Orthopaedic surgeons are involved with the care of patients whose musculoskeletal problems are present at birth or develop at any time during their lifetime. Congenital deformities, trauma, infections, tumors and metabolic disturbances of the musculoskeletal system are problems cared for by the orthopaedic surgeon. These musculoskeletal problems include deformities, injuries, and degenerative diseases of the spine, hands, feet, knee, hip, shoulder, and elbow in children and adults. The orthopaedic surgeon is concerned with primary and secondary muscular problems. They are also involved in the care of patients who manifest the effects of central or peripheral nervous system lesions on the musculoskeletal system.

OTOLARYNGOLOGY

An otolaryngologist-head and neck surgeon is a physician who has been prepared by accredited residency programs to provide comprehensive medical and surgical care of patients with diseases and disorders that affect the ears, the respiratory and upper alimentary systems and related structures: the head and neck in general. The required five years of postgraduate specialty training must include one or more years of general surgery and three or more years of otolaryngology-head and neck surgery in approved residency programs.

The otolaryngologist-head and neck surgeon has a command of the core of knowledge, skills, and understanding of:

> The basic medical sciences relevant to the head and neck; the respiratory and upper alimentary systems; the communication sciences, including knowledge of audiology and speech-language pathology; the chemical senses and allergy, endocrinology and neurology as they relate to the head and neck;
>
> The clinical aspects of diagnosis and the medical and/or surgical therapy or prevention for diseases, neoplasms, deformities, disorders and/or injuries of the ears, the respiratory and upper alimentary systems, the face, jaws and the other head and neck systems. Head and neck oncology and facial plastic and reconstructive surgery are fundamental areas of expertise.

PATHOLOGY

Pathology is that specialty of the practice of medicine dealing with the causes and nature of disease. It contributes to diagnosis, prognosis, and treatment through knowledge gained by the laboratory application of the biologic, chemical, and physical sciences to man, or materials obtained from man.

A certified specialist in pathology is a physician who voluntarily undertook and successfully completed an approved graduate medical education program in pathology and an evaluation process, including an examination administered by The American Board of Pathology. The purpose of the certification process is to assure the public and the medical profession that the pathologist has a level of knowledge, skill, and other abilities deemed necessary for the scientific practice of pathology.

Pathologists are prepared to use their skills and knowledge for the diagnosis, exclusion, and monitoring of disease by means of information gathered from the microscopic examination of tissue specimens, cells, and body fluids, and from clinical laboratory tests on body fluids and secretions. The application of the resulting information to patient care requires pathologists to be especially knowledgeable in the management of laboratories and in data processing and to be conversant with new developments in "high" technology. Pathologists have the clincial training as well as the laboratory expertise to function as consultants to physicians practicing clinical medicine and to patients.

A certified specialist in pathology may subspecialize and become certified in one of the following areas:

Blood Banking: A physician specializing in blood banking is responsible for the maintenance of an adequate blood supply, blood donor and patient-recipient safety, and appropriate blood utilization. Pretransfusion compatability testing and highly specialized testing procedures for antibodies under his/her direction assure the clinician and the patient that blood transfusions, when indicated, are as safe as possible. The blood bank specialist directs the preparation and safe use of specially prepared blood components, including red blood cells, white blood cells, platelets, and plasma constituents.

Chemical Pathology: A chemical pathologist is expert in the biochemistry of the human body as it applies to the understanding of the cause and progress of disease. Chemical pathology entails the application of biochemical data to the exclusion, detection, confirmation, or monitoring of a given disease process. The chemical pathologist functions as a clinical consultant in the diagnosis and treatment of human disease.

Dermatopathology: A dermatopathologist is expert in diagnosing and monitoring diseases of the skin including infections, immunologic, degenerative, and neoplastic diseases. This entails the examination and interpretation of specially prepared tissue sections, celluar scrapings and smears of skin lesions by means of light microscopy, electron microscopy, and fluorescence microscopy. In order to fulfill his consulting role to the patient and to the patient's physician, the dermatopathologist is required to have a good general knowledge of medicine and an in-depth knowledge of dermatology, microbiology, parasitology, new technology, and laboratory management.

Forensic Pathology A forensic pathologist is expert in investigating and evaluating cases of sudden, unexpected, suspicious, and violent death as well as other specific classes of death defined by law. The forensic pathologist serves the public as coroner or medical examiner or by performing medicolegal autopsies for such officials.

Hematology: A hematologist/pathologist is expert in diseases that affect blood cells, blood clotting mechanisms, bone marrow, and lymph nodes. This specialist has the knowledge and technical skills essential for the laboratory diagnosis of anemias, leukemias, lymphomas, bleeding disorders, and blood clotting disorders. The hematologist/pathologist functions as a consultant to all physicians and works closely with clinical hematologists and oncologists (cancer specialists).

Immunopathology: An immunopathologist is concerned with the scientific study of the causes, diagnosis, and prognosis of disease by the application of immunological principles to the analysis of tissues, cells, and body fluids. The immunopathologist is required to have a detailed understanding of the immunologic basis of disease from the perspective of anatomic and clinical pathology and to have the knowledge and ability to interpret laboratory data in relation to patients with immunologic diseases and organ transplant recipients.

Medical Microbiology: A medical microbiologist devotes expertise to the isolation and identification of microbial agents that cause infectious disease. Viruses, bacteria, molds and fungi, as well as single-cell and larger parasites are identified and, where possible, tested for susceptibility to appropriate antimicrobial agents. This pathologist frequently acts as consultant to primary care physicians in the diagnosis and selection of therapy for patients with infectious disease.

Neuropathology: A neuropathologist is expert in the diagnosis of disease of the nervous system and skeletal muscles and functions as a consultant primarily to neurologists and neurosurgeons. The neuropathologist is knowledgeable in the infirmities of man as they affect the nervous and neuromuscular systems be they degenerative, infective, metabolic, immunologic, neoplastic, vascular, or physical in nature. In the diagnosis of these diseases, the neurophathologist employs the special skills and techniques necessary for the scientific study of tissues, cells, and body fluids.

PEDIATRICS

Pediatrics is the specialty of medical science concerned with the physical, emotional, and social health of children from birth to young adulthood. Pediatric care encompasses a broad spectrum of health services ranging from preventive health care to the diagnosis and treatment of acute and chronic diseases.

Pediatrics is a discipline that deals with biological, social, and environmental influences on the developing child and with the impact of disease and dysfunction on development. Children differ from adults anatomically, physiologically, immunologically, psychologically, developmentally, and metabolically. The pediatrician understands this constantly changing functional status of his/her patients incident to growth and development, and the consequent changing standards of "normal" for age.

A pediatrician is a medical specialist who is primarily concerned with the health, welfare and development of children and is uniquely qualified for these endeavors by virtue of interest and initial training. Maintenance of these competencies is achieved by experience, training and continuous education.

A pediatrician is able to define accurately the child's health status, as well as being able to serve as a consultant and to make use of other specialists as consultants. Because children's welfare is heavily dependent on the home and family, the pediatrician supports efforts to create a nurturing environment. Such support includes education about healthful living and anticipatory guidance for both patients and parents.

A pediatrician participates at the community level in preventing or solving problems in child health care and publicly advocates the causes of children.

In addition to the general comprehensive pediatrician, there are subspecialists in pediatrics in a number of subdisciplines such as cardiology, neonatology, endocrinology, hematology-oncology, nephrology, and pulmonology. A later edition of this pamphlet will include a listing and definition of these pediatric subspecialties.

The subspecialty of allergy and immunology is represented by a conjoint board of the American Board of Pediatrics and the American Board of Internal Medicine, called the American Board of Allergy and Immunology; see separate section.

A specialist in Pediatrics may subspecialize in:

Pediatric Cardiologist: A pediatric cardiologist is a medical specialist for children from fetal life to young adulthood who by clinical and research training and experience is competent to provide comprehensive care to patients with cardiovascular problems. The pediatric cardiologist is skilled in selecting, performing and evaulating the structural and functional assessment of the heart and blood vessels and in the clinical evaluation of cardiovascular disease.

Pediatric Critical Care Medicine: The pediatric critical care medicine (PCCM) specialist is a pediatrician with special competence in advanced life support for children from the term or near term neonate to the adolescent. This competence extends to the critical care management of life-threatening organ system failure from any cause in both medical and surgical patients and to the support of vital physiological functions. As a pediatric generalist, the PCCM specialist coordinates the multitude of health care plans prescribed for the patient by other involved physicians. The PCCM specialist has the responsibility to coordinate and order the priority of health care services provided by the Intensive Care Unit.

Pediatric Endocrinologist: A pediatric endocrinologist provides expert care to infants, children and adolescents who have diseases which result from an abnormality in the endocrine glands (glands which secrete hormones). These diseases include but are not limited to diabetes mellitus, growth failure, unusual size for age, early or late pubertal development, birth defects, the genital region, disorders of the thyroid, of the adrenal, and of the pituitary glands.

Pediatric Hematologist-Oncologist: A pediatric hematologist-oncologist is a specialized physician with three interrelated characteristics. First, this physician has been trained in the growth and development of normal children from birth to adulthood as well as in the recognition and management of disease in these age groups. Second, this physician has been trained both in the basic science and clinical expression of hematologic (blood disorders) and oncologic (cancerous) diseases. Third, the work of this physician combines his/her knowledge of general pediatrics and of hematology and oncology in a continuous process of study and service.

Neonatal-Perinatal Medicine: A specialist in neonatal-perinatal medicine is the principal care provider for sick newborn infants. He/she brings extensive experience derived from an intensively focused clinical interest in the problems of newborns. This clinical expertise is used for direct patient care and for consulting with obstetrical colleagues to plan the care of mothers who have high-risk pregnancies. The extensive and focused clinical experience with sick newborns prepares the specialist as a consultant to general pediatricians as they routinely care for most newborns.

Pediatric Nephrologist: A pediatric nephrologist is a medical specialist for children from fetal life to young adulthood who deals with the normal and abnormal development and maturation of the kidney and the urinary tract, the mechanisms by which the kidney can be damaged, the evaluation and treatment of renal diseases, fluid and electrolyte abnormalities, hypertension, and renal replacement therapy.

Pediatric Pulmonologist: The pediatric pulmonologist is dedicated to the prevention and treatment of all respiratory diseases affecting infants, children and young adults. This involves familiarity with organ and cellular pathophysiology, knowledge of growth and development of the lung, assessment of respiratory function in infants and children, experience with a variety of invasive and noninvasive diagnostic techniques and design of clinical investigation.

PHYSICAL MEDICINE AND REHABILITATION

Physical Medicine and Rehabilitation, also referred to as Rehabilitation Medicine, is the medical specialty concerned with diagnosing, evaluating and treating patients with impairments and/or disabilities which involve musculoskeletal, neurologic, cardiovascular or other body systems. The primary focus is on maximal restoration of physicial, psychological, social and vocational function and on alleviation of pain. For diagnosis and evaluation, a physiatrist may include the techniques of electromyography and electrodiagnosis as supplements to the standard history, physical, x-ray and laboratory examinations. In addition to traditional treatment modes the specialist in physical medicine and rehabilitation may use therapeutic exercise, prosthetics, orthotics, and mechanical and electrical devices.

PLASTIC SURGERY

The specialty of Plastic Surgery deals with the repair, replacement and reconstruction of defects of form and function of the integument and its underlying musculoskeletal system, with emphasis on the craniofacial structures, the oropharynx, the upper and lower limbs, the breast, and the external genitalia. It includes aesthetic surgery of structures with undesirable form.

Special knowledge and skill in the design and transfer of flaps, in the transplantation of tissues, and in the replantation of structures are vital to these ends, as is skill in excisional surgery, in management of complex wounds, and in the use of alloplastic materials.

Knowledge of surgical design, surgical diagnosis, surgical and artistic anatomy, surgical pathology, surgical oncology, surgical physiology and pharmacology and bacteriology, biomechanics, embryology, and surgical instrumentation are fundamental to this specialty.

The judgment and technical capability for achieving satisfactory surgical results are mandatory qualities for the plastic surgeon.

PREVENTIVE MEDICINE

Preventive Medicine is that specialty which focuses on the health of individuals and defined populations in order to protect, promote and maintain health and well-being, and to prevent disease, disability and premature death.

In addition to the knowledge of basic and clinical sciences and the skills common to all physicians, the distinctive components of Preventive Medicine include:

1. Biostatistics
2. Epidemiology
3. Health services administration
4. Environmental and occupational influences on health
5. Social and behavioral influences on health
6. Measures which prevent the occurrence, progression and disabling effects of disease or injury.

PSYCHIATRY

These specialists deal with diagnosis, treatment and prevention of mental, emotional and/or behavioral disorders. They also enhance the adaptation of individuals who are coping with stress, crises, and other problems in living.

A psychiatrist may subspecialize in:

Child Psychiatry: A child psychiatrist is a psychiatrist with specialty qualification in the diagnosis and treatment of children, adolescents and their families.

RADIOLOGY

Therapeutic Radiology (Radiation Oncology) is that branch of Radiology which deals with the therapeutic applications of radiant energy and its modifiers and the study and management of disease, especially malignant tumors.

Diagnostic Radiology is that branch of Radiology which deals with the utilization of all modalities of radiant energy in medical diagnoses and therapeutic procedures utilizing radiologic guidance. This includes, but is not restricted to, imaging techniques and methodologies utilizing radiations emitted by x-ray tubes, radionuclides, thermagraphic devices, ultrasonographic devices, and the radio-frequency electromagnetic radiation emitted by atoms.

Nuclear Radiology is that branch of Radiology which involves the analysis and imaging of radionuclides and radiolabeled substances in vitro and in vivo for diagnosis and the administration of radionuclides and radiolabeled substances for the treatment of disease.

Radiological Physics is that branch of medical physics which includes therapeutic radiological physics, diagnostic radiological physics, and medical nuclear physics; including radiation safety.

Therapeutic Radiological Physics is that branch of medical physics which deals with (1) the therapeutic applications of roentgen rays, of gamma rays, of electron and other charged particle beams, of neutrons, and of radiations from sealed radionuclide sources, and (2) the equipment associated with their production and use.

Diagnostic Radiological Physics is that branch of medical physics which deals with (1) the diagnostic applications of roentgen rays, of gamma rays from sealed sources, of ultrasonic radiation, and of radio-frequency radiation, and (2) the equipment associated with their production and use.

Medical Nuclear Physics is that branch of medical physics which deals with (1) the therapeutic and diagnostic application of radionuclides (except those used in sealed sources for therapeutic purposes), and (2) the equipment associated with their production and use.

GENERAL SURGERY

A general surgeon is a specialist prepared to manage a broad spectrum of surgical conditions affecting almost any area of the body. The surgeon establishes the diagnosis and provides the preoperative, operative and postoperative care to surgical patients and is usually responsible for the comprehensive management of the trauma victim and the critically ill. During at least a five-year educational period after obtaining a medical degree, the surgeon has acquired knowledge and technical skills in problems relating to the head and neck, breast, abdomen, extremities, and the gastrointestinal, vascular and endocrine systems. The surgeon uses a variety of diagnostic techniques, including endoscopy, for observing internal structures, and may use specialized instruments during operative procedures. A general surgeon is expected to be familiar with the salient features of other surgical specialties in order to recognize problems in those areas and to know when to refer a patient to another specialist.

Other areas of special expertise are recognized within the discipline of general surgery, requiring additional training and further examination:

General Vascular Surgery: A surgeon with special qualifications in the management of surgical disorders of the blood vessels excluding those to the heart, lungs or brain.

Pediatric Surgery: A surgeon with special qualifications in the management of surgical conditions in premature and newborn infants, children, and adolescents.

Surgical Critical Care: A surgeon with special qualifications in the management of the critically ill patient, particularly the trauma victim, and the postoperative patient in the emergency department, intensive care unit, trauma unit, burn unit, and other similar settings.

THORACIC SURGERY

Thoracic Surgery encompasses the operative, peri-operative care, and critical care of patients with pathologic conditions within the chest. Included is the surgical care of coronary artery disease, cancers of the lung, esophagus and chest wall, abnormalities of the great vessels and heart valves, congenital anomalies and tumors of the mediastinum. The management of the airway and injuries of the chest is within the scope of the specialty.

Certification by the American Board of Thoracic Surgery requires previous certification by the American Board of Surgery, plus a minimum 2-year period of training in thoracic surgery, as well as passage of a two-part examination administered by the American Board of Thoracic Surgery. Thoracic surgeons have the knowledge, experience, and technical skills to diagnose accurately, to operate upon safely and to effectively manage patients with intrathoracic maladies. This requires substantial knowledge of cardio-respiratory physiology and oncology, as well as capability in the use of extracorporeal circulation, intra-aortic balloon support, pacemakers, pleural drainage, respiratory support systems, endoscopy, and invasive and non-invasive diagnostic techniques.

UROLOGY

A specialist in Urology is a physician who has fulfilled the requirements of, and is certified by, The American Board of Urology. He is competent to manage benign and malignant medical and surgical disorders of the adrenal gland and of the genitourinary system. Urologists have comprehensive knowledge of, and skills in, endoscopic, percutaneous, and open surgery of congenital and acquired conditions of the reproductive and urinary systems and their contiguous structures.

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The American Board of Medical Specialties

One Rotary Center
Suite 805
Evanston, IL 60201
312/491-9091

ALLERGY AND IMMUNOLOGY
American Board of Allergy and Immunology
University City Science Center
3624 Market Street
Philadelphia, PA 19104

ANESTHESIOLOGY
American Board of Anesthesiology
100 Constitution Plaza
Hartford, CT 06103

COLON & RECTAL SURGERY
American Board of Colon and Rectal Surgery
8750 Telegraph, Suite 410
Taylor, MI 48180

DERMATOLOGY
American Board of Dermatology
Henry Ford Hospital
Detroit, MI 48202

EMERGENCY MEDICINE
American Board of Emergency Medicine
200 Woodland Pass, Suite D
East Lansing, MI 48823

FAMILY PRACTICE
American Board of Family Practice
2228 Young Drive
Lexington, KY 40505

INTERNAL MEDICINE
American Board of Internal Medicine
University City Science Center
3624 Market Street
Philadelphia, PA 19104

NEUROLOGICAL SURGERY
American Board of Neurological Surgery
P.O. Box 4056
Chapel Hill, NC 27515-4056

NUCLEAR MEDICINE
American Board of Nuclear Medicine
900 Veteran Avenue, Room 12-200
Los Angeles, CA 90024

OBSTETRICS & GYNECOLOGY
American Board of Obstetrics & Gynecology
4225 Roosevelt Way, N.E., Suite 305
Seattle, WA 98105

OPHTHALMOLOGY
American Board of Ophthalmology
111 Presidential Boulevard, Suite 241
Bala Cynwyd, PA 19004

ORTHOPAEDIC SURGERY
American Board of Orthopaedic Surgery
737 North Michigan Avenue, Suite 1150
Chicago, IL 60611

OTOLARYNGOLOGY
American Board of Otolaryngology
5615 Kirby Dr., Suite 936
Houston, TX 77005

PATHOLOGY
American Board of Pathology
5401 West Kennedy Boulevard
PO Box 25915
Tampa, FL 33622

PEDIATRICS
American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514

PHYSICAL MEDICINE AND REHABILITATION
American Board of Physical Medicine and Rehabilitation
Suite 674, Norwest Center
21 First Street S.W.
Rochester, MN 55902

PLASTIC SURGERY
American Board of Plastic Surgery
1617 John F. Kennedy Blvd., #860
Philadelphia, PA 19103

PREVENTIVE MEDICINE
American Board of Preventive Medicine
Department of Community Medicine
Wright State University School of Medicine
PO Box 927
Dayton, OH 45401

PSYCHIATRY AND NEUROLOGY
American Board of Psychiatry and Neurology
500 Lake Cook Rd., #335
Deerfield, IL 60015

RADIOLOGY
American Board of Radiology
300 Park, Suite 440
Birmingham, MI 48009

SURGERY
American Board of Surgery
1617 John F. Kennedy Blvd., Suite 860
Philadelphia, PA 19103-1847

THORACIC SURGERY
American Board of Thoracic Surgery
One Rotary Center, Suite 803
Evanston, IL 60201

UROLOGY
American Board of Urology
31700 Telegraph Road, Suite 150
Birmingham, MI 48010

Publications Available from ABMS

Directories:

THE ABMS COMPENDIUM OF CERTIFIED MEDICAL SPECIALISTS. Biographic data for certified specialists and subspecialists is published biennially in a 7-volume set. Available in June of even years with a SUPPLEMENT in odd years.

Individual specialty directories are also published biennially.

Casebound Reference Works:

EVALUATION OF NONCOGNITIVE SKILLS AND CLINICAL PERFORMANCE (1982). 234 pp. $24.95

EVALUATING THE SKILLS OF MEDICAL SPECIALISTS (1983) 528 pp. $39.95

ORAL EXAMINATIONS IN MEDICAL SPECIALTY BOARD CERTIFICATION (1983) 138 pp. $29.95

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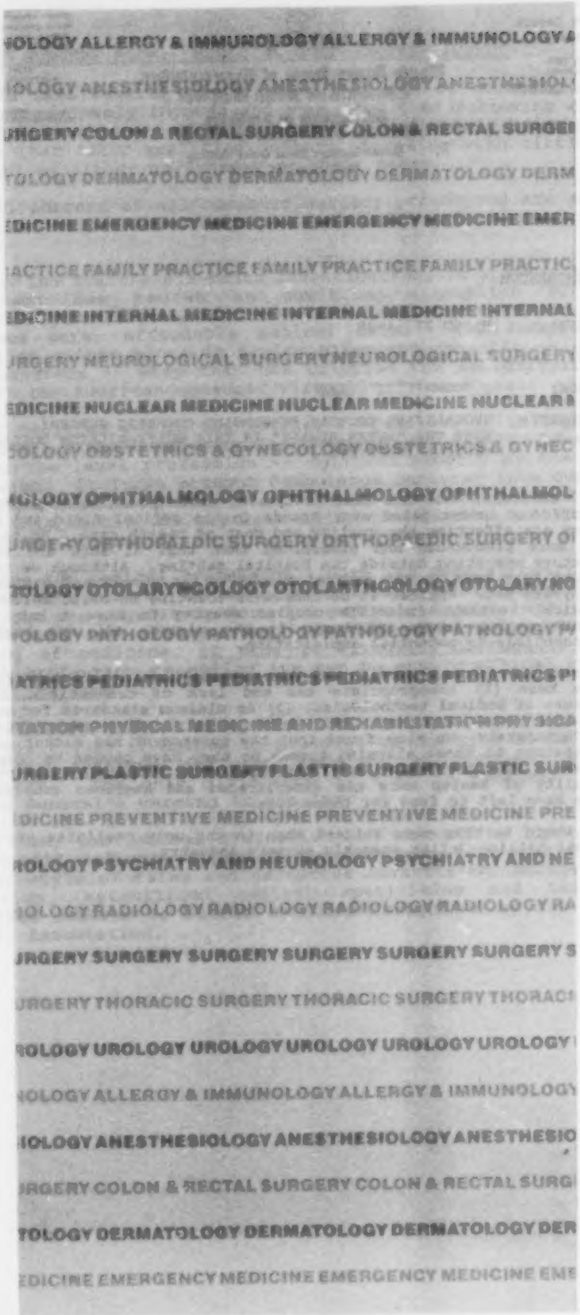
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101st Congress

United States House of Representatives
Committee on Small Business
Subcommittee on Regulation,
Business Opportunities, and Energy
B-363 Rayburn House Office Building
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MINORITY SUBCOMMITTEE PROFESSIONAL
STAFF MEMBER
202-225-[illegible]

MEMORANDUM

DATE: MARCH 27, 1989

TO: CHAIRMAN RON WYDEN

FROM: SUBCOMMITTEE STAFF

SUBJECT: UNQUALIFIED DOCTORS PERFORMING COSMETIC SURGERY: MUST THE "BUYER BEWARE" IN THIS MULTI-BILLION DOLLAR MEDICAL INDUSTRY?

Mr. Chairman, over the last two years, under your leadership the staff has investigated many trends in the medical field and how they are affecting the quality and cost of health care. No trend is more pronounced and widespread than that of more and more doctors operating outside the hospital setting. Although we have found that most in the medical community are honest and ethical, many are not. Whether it be consumers counting on safe, reliable medical testing, infertile couples seeking to have a baby or those seeing lumps and bumps in the mirror, all are highly susceptible to potential explcitation.

The common thread through all the subcommittee's investigations has been (1) inappropriate use and lack of credentials, (2) misuse of medical technologies, (3) no minimum standards for out-patient facilities and (4) false or misleading advertising. Unfortunately, we also found that the government has either been oblivious to these alarming trends or they have chosen to ignore them. The government has abdicated its responsibility, the quality of health care has deteriorated and American consumers has been left to fend for themselves.

No where is this more evident than in the ugly realities of the multi-billion dollar cosmetic surgery industry.

COSMETIC SURGERY BOOM: MEDICINE GOES MADISON AVENUE

Over the last several years, many patients of cosmetic surgery have been seriously injured and some have died following elective cosmetic procedures. It appears that the field is being overrun by less than fully qualified doctors operating with little or no oversight by either government or their peers.

Fully 95 percent of all cosmetic surgery procedures are now done outside of hospitals, in doctors' offices or in limited service clinics.

Based on the staff's six-month investigation, it appears that the government has become an unwitting accomplice by making consistently uninformed and ill-conceived decisions on how to guarantee safe, affordable medical care. The Federal Trade Commission stands alone in having taken one dramatic -- and many say disastrous -- step that has crippled the medical profession and left the American consumer virtually defenseless.

The FTC declared war on the learned professions as it implemented the Federal Trade Commission Improvement Act of 1975. Advertising came to the legal profession -- followed shortly by the medical profession. It first brought "ambulance chasers" into our living rooms during prime time. According to some doctors and lawyers alike, this single act may be a major contributor to our current malpractice crisis.

Then came the medical profession. With its federal court victory over the AMA and two Connecticut medical organizations, the FTC threw open the regulatory door for medical advertising. Not only did it send the message that the FTC would not prohibit the peddling of medicine, it made it virtually impossible for the medical profession to police its own to ensure ethical standards and quality care.

That history shows that the FTC miscalculated badly and dangerously when it opened up medicine to the kind of advertising previously reserved for the ABCs -- automobiles, beer and cigarettes. The only difference is that in doctors' ads, the Surgeon General's warning is missing.

Until then, the medical profession had managed to limit the old "snake oil" salesman approach to medicine. To curb that 19th Century style of false and deceptive advertising, doctors formed societies, established medical specialties and tested and certified members to boards formally recognized by the American Medical Association.

Now, the barn door has swung open and the quacks have waddled out. History has begun to repeat itself.

This should come as no surprise to the FTC. The agency actually anticipated and accepted that there would be serious risks to patients. As one FTC staffer said,

> "I won't deny the fact that some people will go into brain surgery and have consequences that we all don't want. There will be costs -- really serious costs -- but the benefits are that we will know what the hell is going on in the medical marketplace."

The FTC was right. We do know much more about the medical marketplace. We know that most patients take at face value cosmetic surgeons' ads. We know that they think most cosmetic surgery is safe. We know that they think it's safe to have surgery done in doctors' offices, not just in hospitals. We know that they aren't as careful selecting a doctor because they've been led to believe that virtually anyone can do these "simple" procedures and they can do them virtually anywhere. We know that thanks advertising pandering to underestandable interest in our society's preoccupation with youth hundreds of thousands of Americans are having dozens of these procedures. And finally, we know that the FTC's medical marketplace has become a multi-billion dollar industry in the cosmetic surgery field alone.

Unfortunately, we also know that countless patients are being injured. They are being physically and emotionally scarred and they are being financially drained.

Even when potential patients try to be "good medical consumers," they run into a stone wall erected by state and federal governments, medical societies and individual doctors themselves. With a lot of help from the FTC and some in the medical profession, it has become virtually impossible for patients to tell who is a good, qualified doctor and who is not.

And the marked trend toward outpatient surgery has removed the last vestige of accountability for many doctors. No hospital review board verifies the quality of these surgeons' work. No one guarantees whether the "operating room" has even basic life support equipment. No one ensures that the doctor has good, qualified staff to give anesthetic, to monitor the patient and to respond quickly should complications arise.

The frightening result may be that the new back alley of medicine has become the doctor's office itself. We have found that, incredibly, any doctor who manages to graduate from medical school, and receive a state license, can do anything, be anything. Anyone with a medical degree and a state license can do brain surgery, face lifts, breast reductions or enlargements-- even open heart surgery.

This situation exists in every state in the country. But many believe such an environment is far from ethical. Competition has, indeed, come to the medical profession.

WHO'S WHO IN MEDICINE?

Over the years, the "Good Housekeeping Seal of Approval" in medicine has been board certification in a given specialty or area of expertise. But that distinction is murky in cosmetic surgery.

A consumer used to be able to count on a "board certified" doctor having the following qualifications;

- four years of post-graduate medical school;
- three to seven years residency training;
- an unrestricted license to practice; and
- passing a comprehensive medical specialty examination.

But in cosmetic surgery, nearly all boards claim to offer expertise in some procedures. The AMA's American Board of Medical Specialties has approved 23 such boards -- including several claiming to be qualified to do various cosmetic surgery procedures. Thanks to the FTC, however, anyone and any group can create a board, call itself anything and issue certificates suitable for framing. So far, 102 of these self-designated boards have sprung up.

The public is legitimately confused. Not only are individual doctors vying for the public's confidence -- and dollars. Boards themselves engage in what Supreme Court Justice Potter Stewart called "an unseemly rivalry which would enlarge the opportunities of the least scrupulous."

Millions of dollars are spent each year by plastic surgeons, otolaryngologists (ear, nose and throat specialists), eye surgeons and others to convince the public that they are the best. Inter-specialty rivalry has doctors grasping for the golden ring of cosmetic surgery. MacDonalds, Burger King and Wendy's have nothing over these desperate doctors -- many of whom feel that they can't afford not to advertise. Virtually all of them take credit for inventing and perfecting each procedures. And all of them proclaim that the bottom line is patient safety.

"BRAND X" OR "GRADE A"? -- ANATOMY OF AN AD

In an effort to see whether the nation was being blanketed with false, deceptive and misleading advertising, the staff collected and reviewed thousands of sample ads. The Congressional Research Service surveyed six major city magazines for the year 1988, specifically at the subcommittee's request. The subcommittee also analyzed yellow page advertisements for eight other metropolitan markets. Additionally, newspaper ads were reviewed on a random basis.

That review suggests that what had become a way of life for the people of Rodeo Drive in Beverly Hills, has migrated to Main Street, U.S.A. We found the Madison Avenue approach to medical care. The staff has concluded that the field of cosmetic surgery is practicing "Yellow Page Professionalism."

After interviewing numerous doctors from many specialties, lawyers and consumers, the subcommittee staff believes that ads which state, lead one to conclude and purposely omit information are attempting to mislead the consumer. The staff believes that such advertising falls clearly within the jurisdiction of the FTC and should be reviewed by the Commission for appropriate legal action.

The staff has identified the following type of cosmetic surgery ads that should send a red warning flag up to the consumer and the FTC. Advertisements that:

- contain promises about the physical results of surgery;
- contain statements about the surgical procedure;
- contain claims about the innovative character of an operation;
- contain false claims about the physician or his or her staff;
- contain so-called "before and after" photographs, with the "after" photograph posed in a more favorable angle and lighting;
- show the results of one patient's experience or one person's testimonial to apparently imply and mislead other people to conclude that anyone having the same operation can and should have similar results;

- utilize truthful information in a manner that may mislead potential patients as to the qualifications of the advertising physician. An example is one physician who included his membership in the AMA as part of his qualifications. Membership in the AMA is not a function of professional skill;
- assert that a physician is a qualified as a "board certified cosmetic surgeon" when no board of that title is recognized by the American Board of Medical Specialties;
- claim board certification when they are actually certified in other specialties having little or nothing to do with the cosmetic surgery procedures being performed;
- advertise credentials, perhaps impressive to lay persons but medically meaningless, including authorship of articles published in obscure medical journals;
- state doctor inventions of surgical instruments;
- state special residency training and expertise;
- claim state-of-the-art facilities and invite visits by patients who want to make comparisons. Most potential patients have no way to judge its adequacy and medical necessity, and often are mislead by the "Tokyo effect" of fancy gadgets with lights, bells and whistles to suggest safety and state-of-the-art technology;
- lure people into an office by providing something free. The staff believes such ads lead to "hard sell" techniques used once the patient arrives in the office;
- emphasize the reasonableness of fees and the easy financing that's available;
- utilize photographs of attractive models who in most cases have little or no relationship to any cosmetic surgery actually performed on on the model. The staff believes that psychologically appealing advertising appears to minimize the potential health risks of these surgical procedures; and
- fail to mention even the name of the operating surgeon.

WHO'S WATCHING THE STORE?

> "Freedom of speech doesn't give a person the right to yell "fire" in crowded theater, Supreme Court Justice Oliver Wendell Holmes Jr. once noted. Nor should it give con artists the right to promote health frauds through ads in print or on the air. Yet, health fraud lives and even thrives, in no small part because of successful advertising."

One would hope that this warning would be the primer for FTC attorneys charged with protecting the public from false, deceptive and misleading ads -- and the resulting risk to their health. Instead, that quote from "Critiquing Quack Ads" is from a Food and Drug Administration advisory to consumers.

The FTC is still no where to be seen. FDA Commissioner Frank Young told this subcommittee just last week that medical quackery is alive, well and thriving, estimating the costs to consumers at between $10 billion and $40 billion per year. Apparently his agency -- which has little control over false advertising -- is more aware, more concerned and more aggressively trying to protect the public than the FTC -- with its virtually unlimited authority to prohibit such exploitation.

PURPOSE OF SUBCOMMITTEE HEARINGS

Some say the issue is quality. Some say it's dollars and cents. Some say it's a complicated turf battle pitting one medical specialty against another. In any case, the FTC is merely sticking its bureaucratic head in the sand, leaving the hapless medical consumers to fend for themselves. Witnesses before the subcommittee's first hearing on April 4, will include victims of botched cosmetic surgery and representatives from the medical community. Witnesses at the second hearing, on May 2, will include the FTC, the FDA, officials from state licensing and quality assurance boards and medical accrediting societies.

AAAPSF
AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES, INC.
ACCREDITATION OFFICE: 1202 ALLANSON ROAD, MUNDELEIN, ILLINOIS 60060 / (312) 949-6058

June 26, 1989

Frank Papineau
Investigator
Subcommittee on Regulations &
Small Business Opportunity
B-363 Rayburn Building
Washington, DC 20515

Dear Mr. Papineau:

Enclosed please find the facility listing for AAAAPSF accredited facilities. Due to the constant changes and updates in the processing of facilities, the numbers may vary from the numbers provided in the testimony of Dr. Truppman.

These facilities are listed by State, Class (according to anesthesia used) and then by Director's Name.

If you have any questions, please feel free to contact me. I will be at the Washington Hilton Hotel [(202)483-3000] if you need to reach me, after 12:30 p.m.

Sincerely,

Edward J. Stygar, Jr.

Edward J. Stygar, Jr.
Executive Director
AAAAPSF Office

Encl.

President
EDWARD S. TRUPPMAN, M.D.
No. Miami Beach, Florida

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Metairie, Louisiana

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Tucson, Arizona

RICHARD H. WALDEN, M.D.
Mineola, New York

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
CARLSEN, LLOYD N	COSMETIC SURGERY HOSPITAL WOODBRIDGE,ONTARIO	4650 HIGHWAY 01 CANADA		L4L1S7	
SCHWARZ, GASTON MD	PLASTIC & AEST SURG CNTR, 1506 AVE DR PENFIELD	MONT. INC. MONTREAL, QUEBEC		H3G 1B9	
POY, NEVILLE G	PLASTIC,RECONST,& COSM. SURG. WILLOW DALE	2255 SHEPPARD AVE W SUITE W312 ONTARIO, CANADA		M2J4Y1	
WYSHYNSKI, PETER E	KITCHENER-WATERLOO PLAS SURG KITCHENER, ONTARIO	18 FINE STREET SUITE 403 CANADA		N2H5Z8	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
UBINSON, O. GORDON	ALABAMA PLASTIC SURGERY CTR SUITE 203	2022 BROOKWOOD MEDICAL CTR DR BIRMINGHAM	AL	35209	1
ORTHINGTON, JAMES W., MD	1945 FLORENCE BLVD.	WORTHINGTON CLINIC FLORENCE	AL	35630	1
URLISON, PAT/DUNAGAN,DEASON	PLASTIC SURGERY CLINIC SUITE 1421	303 WILLIAMS HUNTSVILLE	AL	35801	1
ONTGOMERY, H.T.	AESTHETIC & PLASTIC SGY CLINIC 901 EAST SOUTH BLVD	MONTGOMERY	AL	36116	1

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
DEMPSEY, PAUL D., MD	PLAS. SGY. P.C. SUITE 111	2355 N. WYATT TUCSON	AZ	85712	1
ANDERSON, RICHARD D.,MD,FACS.	VALLEY PLASTIC SURGERY CENTER SUITE 212	10250 N. 92ND ST. SCOTTSDALE	AZ	85258	1

```
DIRECTOR'S NAME             FACILITY NAME                ADDRESS
                                  ADDRESS LN.2                  CITY               STATE ZIP CODE  CL

                            AGOURA OAKS MEDICAL CENTER   28222 AGOURA ROAD
TERINO, EDWARD OWEN                                             AGOURA             CA   91301
                            ANTHONY B SOKOL MD INC       435 NO ROXBURY DRIVE #200
SOKOL, ANTHONY B                                                BEVERLY HILLS      CA   90210
                            OFFICES OF HARRY A GLASSMAN,MD 120 S. SPAULDING DR., STE 205
KOPLIN, LAWRENCE M, MD                                          BEVERLY HILLS      CA   90212


                            ROBERT P SENGELMANN MD INC   7345 MEDICAL CENTER DRIVE
SENGELMANN, ROBERT P                                            CANOGA PARK        CA   91307
                                                         5400 BALBOA BOULEVARD
NEMETZ, JOSEPH C.                                               ENCINO             CA   91316
                                  SUITE 111
MARSCHALL, FRANK E                                                                 CA   91436
                                  16260 VENTURA BLVD SUITE 830  ENCINO
                                                         16633 VENTURA BOULEVARD
ROSENTHAL, SHELDON A. E.                                        ENCINO             CA   91436
                                  SUITE 110
                            PAUL D MABIE MD INC          2720 N HARBOR BLVD SUITE 300
MABIE, PAUL D                                                   FULLERTON          CA   92635
                                                         SOUTH ELISEO MEDICAL CENTER
AKIN, RICHARD L             MINAMI, ROLAND T                    GREENBRAE          CA   94904
                                  1240 S. ELISEO         PLASTIC SURGICLINIC
SINGER, ROBERT              ROBERT SINGER, MD, INC              LA JOLLA           CA   92037
                                  9834 GENESEE AVE, #100 LA JOLLA COSMETIC SGY CENTER
DINNER, MELVYN J., MD       OLESON, R. MERREL, MD               LA JOLLA           CA   92037
                                  484 PROSPECT STREET    9900 GENESEE AVENUE
EWIS, CARSON M              CARSON M. LEWIS, M.D., INC.         LA JOLLA           CA   92037
                                  SUITE B                9834 GENESEE AVENUE
WOLF, DAVID                                                     LA JOLLA           CA   92037
                                  SUITE 310              528 NAUTILUS
RANT, STEPHEN M., MD                                            LA JOLLA           CA   92037
                                                         ERVING S WHEELER MD MED. CORP
RVIN S WHEELER, MD                                              LA MESA            CA   92041
                                  8690 CENTER DRIVE      44404 16TH STREET WEST
MANNING, JOHN J., MD                                            LANCASTER          CA   93534
                                  SUITE 205
```

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
JOY IKONIJA CONNIE S.	LONG BEACH CENTER FOR PLASTIC 920 E. WARDLOW ROAD	SURGERY LONG BEACH	CA	90807	
HICKMAN, DONN M., MD	SUITE #101	4401 ATLANTIC AVE. LONG BEACH	CA	90807	
WILLIAMS, JOHN E	AESTHETICA SUITE P-6	5757 WILSHIRE BLVD LOS ANGELES	CA	90036	
NORTON, EUGENE W	SEIFERT, LAWRENCE N SUITE 1015 E	8631 WEST THIRD STREET LOS ANGELES	CA	90048	
KIRIANOFF, T. GREGORY	A MEDICAL CORPORATION	2080 CENTURY PARK E. #607 LOS ANGELES	CA	90067	
STRICKLAND, DANIEL M., MD	BARTELS, ROGER, MD 966 CASS STREET, SUITE 150	PLASTIC & RECONSTRUCTIVE SURG MONTEREY	CA	93940	
VOLOSHIN, P. JAMES M.D.	NEWPORT INSTITUTE OF PLAS.SURG SUITE 406	360 SAN MIGUEL NEWPORT BEACH	CA	92660	
HEINRICHS, HARVEY MD	SUITE 601	1441 AVACADO NEWPORT BEACH	CA	92660	
LUHAN, JORGE E	JORGE E LUHAN MD INC	1414 AVOCADO AVE #806 NEWPORT BEACH	CA	92660	
BENVENUTI, DAVID MD	355 PLACENTIA #99	MARINERS SURGICENTER NEWPORT BEACH	CA	92663	
AUB,D R / WEBER, JR, J	PALO ALTO CENTER FOR 900 WELCH ROAD - SUITE 402	PLASTIC SURGERY PALO ALTO	CA	94304	
IVERSON, RONALD E	PLASTIC & RECONS SURGERY CTR	1387 SANTA RITA ROAD PLEASANTON	CA	94566	
GLAYBACK, JOHN MD	PLASTIC SURGERY CENTER	2 W. FERN AVE. REDLANDS	CA	92373	

06/26/89

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
MERY, JOHN E. MD	RECON SURG. MED CLINIC, INC.	2001 UNION STREET SAN FRANCISCO	CA	94123	
RISTOW, BRUNO	BRUNO RISTOW MD INC SUITE 502	2100 WEBSTER SAN FRANCISCO	CA	94115	
BROWN, DONALD M., MD	DONALD M. BROWN, MD, INC. SUITE #429	2100 WEBSTER STREET SAN FRANCISCO	CA	94115	
RUGMAN, MARK E	MEK SURGICAL FACILITY	720 NO. TUSTIN AVENUE SANTA ANA	CA	92705	
OEFFLIN, STEVEN M. MD FACS		1530 ARIZONA AVE SANTA MONICA	CA	90404	
THOMPSON, DENNIS P	A NEW LOOK SUITE # 1180-W	2001 SANTA MONICA BLVD SANTA MONICA	CA	90404	
LAVIN, HAROLD D.	MEDICAL CENTER OF SANTA MONICA SUITE 890-WEST	2001 SANTA MONICA BOULEVARD SANTA MONICA	CA	90404	
GROSSMAN, A RICHARD	PLASTIC SURGICENTER	4910 VAN NUYS BLVD SHERMAN OAKS	CA	91403	
EMBERLING, RONALD M., MD,FACS	AMBULATORY SURGICAL CENTER 591 TAHOE KEYS BLVD.,STE. D-5	PO BOX 10010 SOUTH LAKE TAHOE	CA	95731	
FFICE AMBULATORY SUGRERY CTR	RONALD M GEMBERLING, M.D. P.O. BOX 10010	1139 SECOND ST SOUTH LAKE TAHOE	CA	95731	
URLIN JOSEPH R.	PLASTIC SURGRY CRT OF STOCKTON SUITE 405	1805 N. CALIFORNIA ST STOCKTON	CA	95204	
OHRER, PAUL A. MD	PAUL A. ROHRER, MD, INC.	1246 E. ARROW HIGHWAY UPLAND	CA	91786	
ELGADO, CARLOS G., MD	THE PLASTIC SURGICENTRE	112 LA CASA VIA WALNUT CREEK	CA	94598	
ILLIAM J. FISHER	PLASTIC SURGERY ASSOC MED GRP	1250 LA VENTA DRIVE SUITE 202 WESTLAKE VILLAGE	CA	91361	

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL.
MORGAN, L. RICHARD MD.	L. RICHARD MORGAN, M.D., INC. 18 WILLIAMSBURG LANE	STONEBRIDGE PROFESSIONAL VILL. CHICO	CA	95926	
KNOWLTON, EDWARD W.	PLASTIC & RECONSTRUCTIVE SURG BUILDING B, SUITE 110	905 SAN RAMON VALLEY BOULEVARD DANVILLE	CA	94526	
PERRY, ALLAN W	ALLAN W PERRY MD, INC SUITE 118	1808 VERDUGO BLVD GLENDALE	CA	91208	
MANIS, JOHN	PLASTIC SURGERY CENTER	1000 S. ELISEO DR. GREENBRAE	CA	94904	
WOOD, DAVID L	DAVID L WOOD P C	2700 BELLFLOWER BLVD STE 306 LONG BEACH	CA	90815	
FRILECK, STANLEY	SUITE 503	11980 SAN VICENTE LOS ANGELES	CA	90049	
REINISCH, JOHN F.	UNIVERSITY PLASTIC SURGEONS	1245 WILSHIRE BLVD STE 403 LOS ANGELES	CA	90017	
DE SHAZO B W	B W DE SHAZO MD INC SUITE 711	1245 WILSHIRE BLVD LOS ANGELES	CA	90017	
POOMEE, AMORN		1130 COFFEE RD SUITE 5-B MODESTO	CA	95355	
PEARL SAMUEL N	PEARL PLASTIC SURGERY CENTER SUITE #205	525 SOUTH DRIVE MOUNTAIN VIEW	CA	94040	
GRAZER, FREDERIC M.	SUITE 502	1401 AVOCADO AVENUE NEWPORT BEACH	CA	92660	
LASSA, RALPH E II	PLASTIC SURGERY ASSOC	216 HOWARD STREET PETALUMA	CA	94952	

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DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
KNAPP, T. R.	MD CALIF PLASTIC SURG MEDICAL 2650 EDITH AVENUE	GROUP - AMBULATORY SURG UNIT REDDING	CA	96001	
RIEDENTH[illegible], [illegible]R P	SAN FRANCISCO PLASTIC AND 3838 CALIFORNIA ST SUITE 404	RECONSTRUCTIVE SURGERY MEDICAL SAN FRANCISCO	CA	94118	
OUTHER, SHERMAN G., MD	LUCID, MORGAN L., MD 2101 FOREST AVE, SUITE 128	ASSOCIATED PLASTIC SURGEONS SAN JOSE	CA	95128	
ADN, AURO J		1200 N. TUSTIN SANTA ANA	CA	92705	
AGEL, G P	G P NAGEL MD A MEDICAL CORP	427 WEST PUEBLO STREET SANTA BARBARA	CA	93150	
ILVERTON, JOHN S., MD	A PROFESSIONAL CORPORATION	1803 WEST MARCH LANE, SUITE B STOCKTON	CA	95207	
THORRENS, SHELDON J	SHELDON J THORRENS MD INC	23560 MADISON SUITE 112 TORRANCE	CA	90505	
OROCZ, ISTVAN	SUITE 103	2121 YGNACIO VALLEY RD BLDG E WALNUT CREEK	CA	94598	
TEARSTON, G M / GENEDNER, G E		8635 W THIRD STREET #1090 W LOS ANGELES	CA	90066	

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
SPEIRS, ALFRED C	SPEIRS CLINIC FOR PLAS. SURGRY	1490 W. FILMORE COLORADO.SPRINGS	CO	80904	
GROSSMAN, JOHN A.	THE CLINIC FOR PLASTIC SURGERY	310 STEELE STREET DENVER	CO	80206	
MCKINNON, DOUGLAS A	COLORADO CNTRS FOR PLAS SURG. 1700 MARION STREET	DENVER	CO	80218	
EISENBAUM, SIDNEY L., MD.	SHESOL, BARRY F., MD 750 POTOMAC	OUTPATIENT SURGICAL SUITE AURORA	CO	80011	
STORMO, ALAN C.	BOULDER VALLEY SURGERY CTR.INC 2617 BROADWAY	BOULDER	CO	80302	
WALKER IAN G. MD.,PC		320 E. FONTANERO SUITE 305 COLORADO SPRINGS	CO	80907	
HANSON, J R / DUBOIS DAVID D	CO.SPRINGS PLAS SURG CLINIC	2727 NO TEJON COLORADO SPRINGS	CO	80907	
SUMMERS, THOMAS C, MD, PC	THOMAS C. SUMMERS, MD, PC,FACS SUITE 336	4200 W. CONEJOS DENVER	CO	70204	
CHARLES, DAVID M	PLASTIC SURGERY CLINIC	1578 HUMBOLDT STREET DENVER	CO	80218	
KNIZE, DAVID M.	3555 SOUTH CLARKSON	ENGLEWOOD	CO	80110	
MERKEL, WILLIAM D	PLASTIC SURGERY SPECIALISTS PC	2525 NORTH 8TH STREET GRAND JUNCTION	CO	81501	
FAWELL, THOMAS W.	HIGHLANDS RANCH PLAS SURG CTR SUITE 350	206 WEST COUNTY LINE RD. HIGHLANDS RANCH	CO	80126	

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DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
MOYNAHAN, PAULA A., M.D.	MOYNAHAN MEDICAL CENTER	141 EAST MAHI STREET WATERBURY	CT	06702	
CORBO, PHILIP F. MD		2660 MAIN ST. BRIDGEPORT	CT	06606	
HABCOCK, ALBERT L	HARTFORD PLASTIC SURGERY ASSOC	100 RETREAT AVENUE HARTFORD	CT	06106	

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
MAN, DANIEL, MD PA	AESTHETIC PLASTIC SURG. UNIT 851 MEADOWS ROAD - SUITE 222	BOCA RATON	FL	33432	
MERGEN, FRANK A.	PLASTIC SURGERY CENTER 1599 NW 9TH AVENUE	BOCA RATON	FL	33432	
PERSOFF, MYRON MD	STERN, ORRIN MD 950 GLADES RD SUITE 3-C	BOCA RATON PLASTIC SURG ASSOC BOCA RATON	FL	33431	
PETER G. JAMES, MD, PA		951 N.W. 13TH STREET 4A BOCA RATON	FL	33486	
SUPONIC, BARBARA L., RN	AMBULATORY SURGERY CENTER	5817 21ST. AVENUE WEST BRADENTON	FL	34209	
FISHMAN, JOSEPH M., MD,PA	CLEARWATER CENTER FOR COSMETIC 609 LAKEVIEW ROAD	AND PLASTIC SURGERY CLEARWATER	FL	33516	
DREHGEN, CHRISTIAN, MD, PA	CLINIQUE OF PLASTIC SURGERY	3023 EASTLAND BLVD., STE. 107 CLEARWATER	FL	34621	
WELLS, ROBERT L	AESTH & PLASTIC SURGERY CLINIC	1011 JEFFORDS STREET CLEARWATER	FL	33516	
LENTZ, CARL W. MD, FACS, PA		120 NORTH SENECA DAYTONA BEACH	FL	32014	
HOGUE, ROBERT J JR	PLASTIC SURGERY ASSOCIATES 6520 N.W. 9TH BOULEVARD	OF GAINSVILLE GAINESVILLE	FL	32605	
FABRIC, ROBERT K., M.D.	PLASTIC SURGICENTER 4018 SHERIDAN STREET	OF HOLLYWOOD HOLLYWOOD	FL	33021	
KAYE, BERNARD L	PLASTIC SURGERY CLINIC 820 PRUDENTIAL DRIVE	720 HOWARD BLDG JACKSONVILLE	FL	32207	
RAPPERPORT, ALAN S., MD	SUNSET SURGI CENTER	6280 SUNSET DR, SUITE 501 MIAMI	FL	33143	
ROSKIND, JOEL L., MD	DR. ROSKINDS SURGICAL FACILITY SUITE 101	8700 N. KENDALL DR. MIAMI	FL	33176	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
INE, JAY B., MD.		909 NO. MIAMI BEACH BLVD. N. MIAMI BEACH	FL	33162	
ELVANG, L. CHRISTIAN	1351 PINE ST	PINES MEDICAL BUILDING NAPLES	FL	33942	
RUPPMAN, EDWARD S	TRUPPMAN & SCHWARTZ P.A.	1100 N.E. 163RD STREET NO. MIAMI BEACH	FL	33162	
ADLAUER, CHARLES B	CHARLES B RADLAUER MD PA SUITE 510	14800 NORTHWEST 2ND AVENUE NORTH MIAMI BEACH	FL	33169	
ITAN, MICHAEL D.	THE PLASTIC SURGICENTER	1625 US HWY 19 W PALM HARBOR	FL	33563	
ELMAN, DONALD MD	201 N.W. 82ND AVE SUITE 102	BENNETT MEDICAL PLAZA PLANTATION	FL	33324	
NDES, LEWIS D.	COSMETIC & RECONSTRUCTIVE 2901 ST. ISABEL	SURGERY CENTER TAMPA	FL	33607	
OVICK, MAURICE	COSMETIC SURGERY CENTER	13905 BRUCE B DOWNS BLVD TAMPA	FL	33613	
LMQUIST, JOHN D	JOHN D ELMQUIST MD PA	1639 FORUM PLACE SUITE 7 WEST PALM BEACH	FL	33401	
EFR, JAMES T M.D.	MORSE SURGICAL SERVICE & 400 WEST MORSE BLVD	MORSE LDG WINTER PARK	FL	32790	
[illegible] D, JR	CORAL GABLES PLAS SURGERY ASSC	262 ALMERIA AVENUE CORAL GABLES	FL	33134	
SUND, JOHN S	FT MYERS PLASTIC SURGRY CNTR. EVANSWOOD PARK	2685 SWAMP CABBAGE CT FT MYERS	FL	33901	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
HERMAN, STANLEY MD	SHERIDAN HILLS PLAG.SURG.FACIL SUITE C	4050 SHERIDAN STREET HOLLYWOOD	FL	33021	
AKER, T J	GORDON, H L 1501 S MIAMI AVE	BAKER & GORDON PLASTIC SURGERY MIAMI	FL	33129	
IGGIANO DONATO A	TREASURE COAST COSMETIC 1901 PORT ST LUCIE BLVD	SURGERY CENTER PORT ST LUCIE	FL	33452	
OATES, MICHAEL R., MD	SUITE 7W	5425 PARK ST. NORTH ST. PERERSBURG	FL	33709	
HARES, RICHARD E.	COSMETIC SURGERY SUITE	100 FIFTH AVENUE SOUTH ST. PETERSBURG	FL	33701	
EJIA-MILLIAN SILVIO	PLASTIC & COSMETIC SRGY CTR.	3301 66TH STREET NORTH ST. PETERSBURG	FL	33710	
AYNOR, A. CLARK, MD.	STUART PLASTIC SURGERY CTR	845 E OSCEOLA ST STUART	FL	34994	
OORE, CHARLES, MD		1210 MICCOSUKEE RD. TALLAHASSEE	FL	32308	
IZZO, ANTHONY J MD PA		4600 HABANA, SUITE 31 TAMPA	FL	33614	
ILLARD, JR, D RALPH	PLASTIC SURGERY CENTRE	1444 N.W. 14TH AVENUE MIAMI	FL	33125	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
URTEAU, JOHN E.	ATHENS PLASTIC SURGERY CLINIC	2325 PRINCE AVE ATHENS	GA	30606	
UNNA, JOHN, MD	THE PLASTIC SURGICENTER 3280 HOWELL MILL RD SUITE 212	NORTHWEST MED CTR - EAST WING ATLANTA	GA	30327	
EWIS, JOHN R.	CENTER FOR PLASTIC SURGERY INC	365 EAST PACES FERRY ROAD NE ATLANTA	GA	30305	
ARTLEY, JR., JOHN MD	ATLANTA AEST. SGY. CENTER BUILDING #8	4200 NORTHSIDE PARKWAY ATLANTA	GA	30327	
ICHWINE, JR. SAM, MD	N.E. GEORGIA PLASTIC SGY CTR. SUITE B	1296 SIMS STREET, NE GAINESVILLE	GA	30501	
INGER, E RONALD	FINGER & SMITH PLAST SGY ASSOC BUILDING #8	11706 MERCY BLVD. SAVANNAH	GA	31499	
OCHRAN, THOMAS A JR	COLUMBUS PLASTIC AND 2200 NORTH AVENUE	COSMETIC SURGERY, P.C. COLUMBUS	GA	31904	
AVANNAH PLASTIC SURGICENTER	RUF, LAWRENCE E., FAC.DIRECTOR	715 E. 67TH STREET SAVANNAH	GA	31405	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
LOWERS, ROBERT S., M.D.	 677 ALA MOANA BLVD.	SUITE 1011 HONOLULU	HI	96813	
AUI PLASTIC SURGERY	SCHLESINGER, S. LARRY SUITE 300 KAHULUI BLDG	33 LONO AVENUE KAHULUI	HI	96732	

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DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
SULLIVAN C EUGENE	HENDRICKS JOHN L 999 N CURTIS RD 109	IDAHO PLASTIC SURGEONS BOISE	ID	83706	
HAYES, J. EDWARD	333 NORTH FIRST, SUITE 130	BOISE PLASTIC SURG. CLINIC P.A BOISE	ID	83702	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
WARTZ, ROBERT M., MD	COSMETIC & RECON INST., LTD. 845 N MICHIGAN #934 -E	CHICAGO	IL	60611	
ERBER, DIANE L		19150 KEDZIE AVE FLOSSMOOR	IL	60422	
OHAEY, M., MD	HIGHLAND MEDICAL CENTER 2340 HIGHLAND AVENUE	SUITE 360 LOMBARD	IL	60148	
EWELL, III, TODD S., MD	PLASTIC & AESTHETIC SURGERY	895 GENEVA ROAD ST. CHARLES	IL	60174	

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DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE ZIP CODE	CL
ASDAN, MORTON L	HARTER, B. THOMAS P.O. BOX 6048	4006 DUPONT CIRCLE LOUISVILLE	KY 402066048	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	C
ISNER, W. HOWARD	DIJON COSMETIC SURGERY CENTER	5233 DIJON AVE BATON ROUGE	LA	70809	
EAGUE, GRUENWALD, & REILLEY	ASSOCS IN PLAS.&RECON. SURGERY 8425 CUMBERLAND PLACE	BATON ROUGE	LA	70806	
OLON, GUSTAVO A	SURI-UNIT	4204 TEUTON STREET METAIRIE	LA	70002	
RAHAM, JOHN K	PLASTIC SURGERY CENTER	3000 FAIRFIELD AVENUE SHREVEPORT	LA	71104	
ENDERSON, DARRELL	PLASTIC SURGERY ASSOCIATES SUITE 400	1101 SO COLLEGE LAFAYETTE	LA	70503	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
ELMAN, ALAN	MIDDLESEX PLASTIC SURGERY INC	350 UNION AVENUE FRAMINGHAM	MA	01701	
DO, ROBERT F. MD	MID-CAPE SURGICAL CENTER, INC	26 GLEASON STREET HYANNIS	MA	02601	
HEINGOLD, LAURENCE		51 MAIN STREET HYANNIS	MA	02601	
ECKER, MARTIN D.	PLASTIC & RECONSTRUCTIVE 30 WALPOLE STREET	SURGERY OF NORWOOD, INC. NORWOOD	MA	02067	

)IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
OWE, DAVID H. MD	PLASTIC SURGERY SPECIALISTS,PC SUITE 400	2448 HOLLY AVE ANNAPOLIS	MD	21401	
RMIGER, WM. G. MD	CHESAPEAKE PLASTIC SURG. CNTR	1421 S. CATON AVENUE BALTIMORE	MD		
AGASSY CSABA L	TEUNIS, B SCOTT 5454 WISCONSIN AVE SUITE	PLASTIC SURGERY ASSOCIATES PC 1635 CHEVY CHASE	MD	20815	
USSELBERG, LORIN F.	PLASTIC SURGERY OF FREDRICK	1475 TANEY AVE SUITE 101 FREDERICK	MD	21701	
ONVERSE, CHARLES F.	RIVER REACH PLASTIC SURG. CTR SUITE E35, RIVER REACH	790 RITCHIE HIGHWAY SEVERNA PARK	MD	21146	
AHOS, MARIO	SUITE 100	1001 PINE HEIGHTS AVENUE BALTIMORE	MD	21229	
OOPES, JOHN E	JHU PLASTIC SURGERY ASSOCIATES	3801 GREENSPRING AVENUE BALTIMORE	MD	21211	
LATSKY, STANLEY A. MD	122 SLADE PROFESSIONAL CENTER	122 SLADE AVE BALTIMORE	MD	21208	
CGIBBON, BERNARD M	SUITE 36	1205 YORK ROAD LUTHERVILLE	MD	21093	
AMIREZ, MD., OSCAR M.	ORCHARD SQUARE AMB.PLS.SGY.CTR SUITE B-101	1212 YORK ROAD LUTHERVILLE	MD	21093	

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IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
ANELLE, JEAN J MD	FLAG & HAND SURGICAL ASSOC	244 WESTERN AVE PORTLAND	ME	04106	

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IRECTOR'S NAME              FACILITY NAME                    ADDRESS
                                  ADDRESS LN.2                      CITY                  STATE ZIP CODE  CL.

OMEZ, JORGE, MD             BLACKBURN, WM. II, MD FACS.      921 ABBOTT ASSOC-AMB.SURG.FAC
                                  921 ABBOTT RD.                    EAST LANSING            MI   48823
ROGUL MELIH                 PLASTIC SURGERY CENTER OF        FARMINGTON HILLS
                                  28499 ORCHARD LAKE RD.            FARMINGTON HILLS        MI   48018
ANDERWALL, DAVID A., MD     PLASTIC SURGERY ASSOC.           220 LYON N.W.
                                  SUITE 700                         GRAND RAPIDS            MI   49503
EWMAN, FRANK J., MD                                          KALAMAZOO PLASTIC SURGERY, PC
                                  125 WEST WALNUT ST.               KALAMAZOO               MI   49007


EISS, ARNO W., MD                                            800 COOPER STREET
                                  SUITE 01                          SAGINAW                 MI   48602
EWMAN, M. HASKELL           HURON AMBULATORY SURGICAL ASSC 5333 MCAULEY DR STE R-6016
                                                                    YPSILANTI               MI   48197
AWTOF, DAVID B                                               22250 PROVIDENCE DRIVE
                                                                    SOUTHFIELD              MI   48075
LAMI, HAGHIM M., M.D.       PLASTIC SURGERY AFFILIATES, PC 29877 TELEGRAPH RD.
                                  SUITE # 107                       SOUTHFIELD              MI   48034
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IRECTOR'S NAME              FACILITY NAME                  ADDRESS
                                  ADDRESS LN.2                   CITY                 STATE ZIP CODE  CL

UGT, PETER A.               MINNEAPOLIS PLASTIC SURGEONS   4825 OLSON MEMORIAL HIGHWAY
                                  SUITE 200                      MINNEAPOLIS           MN  55422       1
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DIRECTOR'S NAME          FACILITY NAME               ADDRESS
                               ADDRESS LN.2                 CITY                 STATE ZIP CODE  CL

UTEK, F PHILIP           ASSOCIATED PLASTIC SURGEONS    6420 PROSPECT, #115
                                                            KANSAS CITY            MO  64132
EBB, HARRY E             BROADWAY MEDICAL BLDG PLASTIC  PLASTIC SURGERY FACILITY
                               4400 BROADWAY                KANSAS CITY            MO  64111
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IRECTOR'S NAME           FACILITY NAME                  ADDRESS
                               ADDRESS LN.2                   CITY             STATE ZIP CODE  CL

ANSDEN, FRANK T., MD     THE CENTER FOR PLASTIC SURGERY 1203 BROAD AVENUE
                                                              GULFPORT           MS   39501
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IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
EET WALTER J / SLOAN DAVID F	COLLEGE PARK PROF CENTER	2570 17TH STREET WEST # 100 BILLINGS	MT	59102	
ROWN, ROGER G., MD PC		1297 BURNS WAY KALISPELL	MT	59901	

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IRECTOR'S NAME              FACILITY NAME                   ADDRESS
                                   ADDRESS LN.2                     CITY                   STATE ZIP CODE  CL

ALKER, ANDREW WM., MD.      CHARLOTTE PLASTIC SURG. CENTER
                                   2215 RANDOLPH ROAD               CHARLOTTE               NC   28207     1
ANIER, JR VERNE C           VERNE C LANIER JR MD PA         PLASTIC SURGERY CENTER
                                   300 CRUTCHFIELD STREET           DURHAM                  NC   27704     1
INSLOW, ROBERT B.           CAROLINA PLASTIC SURGERY SPEC   2501 NORTH STREET, SUITE 500
                                                                    RALEIGH                 NC   27607     1
SRAEL, J ROBERT             ASHEVILLE AESTHETIC SURGERY     5 LIVINGSTON
                                                                    ASHEVILLE               NC   28801     1

HOMPSON,L K III             DURHAM PLASTIC SURGERY ASSOC    2609 NORTH DUKE ST SUITE 401
                                                                    DURHAM                  NC   27704     1
ITCHENS, T RUSSELL MD                                       1507 WESTOVER TERRACE
                                                                    GREENSBORO              NC   27408     1
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IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
ACIK, PETER T MD	PLASTIC SURGERY CENTER, INC.	57 BAY ST MANCHESTER	NH	03104	

IRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL/
LOWENSTEIN, RICHARD B	OFFICE SURGICAL SUITE	177 NORTH DEAN STREET ENGLEWOOD	NJ	07631	(
AMICO RICHARD A.	SUITE 3NE	180 N. DEAN STREET ENGLEWOOD	NJ	07631	(
TEINBERG, URSULA W. MD	PLASTIC SURGICAL ASSOCIATES	1024 PARK AVENUE PLAINFIELD	NJ	07060	(
R MAHMOUD A	AMBULATORY PLASTIC SURGERY	511 SOUTH ORANGE AVENUE SOUTH ORANGE	NJ	07079	(
EDDY, LOKA N., MD	IMAGE PLASTIC SURGERY CENTER	1400 KENNEDY BLVD. UNION CITY	NJ	07087	(
OBBY MEIJER, MD	THE PEER GROUP PLAS SURG CNTR	124 COLUMBIA TURNPIKE FLORHAM PARK	NJ	07932	1
AXT, SHERWOOD	LIPSON, DAVID 351 EVELYN STREET	PLAST.SURG.& DERMAT. ASSOC, PA PARAMUS	NJ	07652	1
	ASSOC IN PLAS & AESTH SURGERY	522 E BROAD STREET WESTFIELD	NJ	07090	1

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DIRECTOR'S NAME               FACILITY NAME                  ADDRESS
                                    ADDRESS LN.2                     CITY                 STATE ZIP CODE  CL

OODING, RICHARD A. MD         R A GOODING PA AMBUL SURG FAC  2207 SAN PEDRO NE
                                                                     ALBUQUERQUE            NM   87110
                              HERHAHN, FRANK T MD            COSME CENTER
                                    120 VASSAR SE                    ALBUQUERQUE            NM   87106
THOMAS A HARBETE MD PA        NORTHSIDE MEDICAL BUILDING     6100 PANAMERICAN FREEWAY N.E.
                                    SUITE 460                        ALBUQUERQUE            NM   87109
HUDSON, PATRICK A.            THE CENTER FOR AESTHETIC SRGY  715 GRAND AVE NE
                                    SUITE 301                        ALGUQUERQUE            NM   87102
ILLER, ROGER H                ROGER H MILLER MD, PA          465 ST MICHAELS DRIVE STE 113
                                                                     SANTA FE               NM   87501
```

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
HETTER, GREGORY P	LAS VEGAS COSMETIC SRGY.SPCLTY	3017 W. CHARLESTON BLVD LAS VEGAS	NV	89102	
STRAND, GARETH W. MD	NO. NEVADA PLASTIC SURG ASSOC	932 RYLAND STREET RENO	NV	89502	
VINNIK, CHARLES A		1580 E DESERT INN ROAD LAS VEGAS	NV	89109	

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	C
ELLIOTT, JR, RAY A	ALBANY PLASTIC SURGEONS ASSOC	60 HACKETT BLVD ALBANY	NY	12209	
MANAKOS, MICHAEL G.	HUNTING SURGERY CENTER	380 PARK AVE. HUNTINGTON, L.I.	NY	11743	
WALDEN, RICHARD H	LONG ISLAND PLASTIC SURGERY 110 WILLIS AVENUE	GROUP PC MINEOLA	NY	11501	
KORNGOLD, LOUIS, MD, PC.	GLASSMAN, LAWRENCE S., MD, PC	125 S. MAIN STREET NEW CITY	NY	10956	
PITMAN, GERALD H	PITMAN AMBULATORY SURGERY UNIT	170 E 73RD STREET NEW YORK	NY	10021	
FODOR, PETER B., MD		200 EAST END AVENUE NEW YORK	NY	10128	
SHIP, ARTHUR G	WEISS, PAUL R. 999 FIFTH AVENUE	METRO.PLASTIC SURGERY ASSOC. NEW YORK	NY	10028	
CUCIN, ROBERT L. MD	OFFICE OPERATING ROOM	8 EAST 62ND STREET NEW YORK	NY	10021	
REED, LAWRENCE S., MD		45 EAST 85TH STREET NEW YORK	NY	10028	
LEFKOVITS, GEORGE		9 E 62ND STREET NEW YORK	NY	10021	
LOGOSSO, RONALD D.	HORIZONS IN PLASTIC SURGERY STONYBROOK MEDICAL PARK	2500 RTE 347 BLDG 14 NY	NY	11790	
BERNARD, ROBERT W.	MORELLO, DANIEL C.	10 CHESTER AVENUE WHITE PLAINS	NY	10601	
KERCHNER, CLOYD C	IN-OFFICE OPERATING ROOM	90 SOUTH STREET GLENS FALLS	NY	12801	
BONANNO, PHILLIP C.	PLASTIC RECONSTRUCTIVE 101 S. BEDFORD RD	SURGERY MOUNT KISCO	NY	10549	
PISANI, ANTHONY R	SUITE 104-106	666 LEXINGTON AVE MT. KISCO	NY	10549	

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CI
REES, THOMAS D	THOMAS D REES, MD PC	176 EAST 72ND STREET NEW YORK	NY	10021	
COBURN, RICHARD J	OFFICE SURGICAL SUITE	6 EAST 78TH STREET NEW YORK	NY	10021	
ASTON, SHERRELL J., MD		728 PARK AVENUE NEW YORK	NY	10021	
FOX, PATRICIA A	GOODMAN, STEVEN J 1411 UNION STREET	ENGLEBARDT, CARL SCHENECTADY	NY	12308	
MARKS, FREDRICK		1460 VICTORY BLVD. STATEN ISLAND	NY	10301	
ARMENTA, ENRIQUE	LEHRMAN, ARTHUR 2200 EAST GENESEE STREET	CNY PLASTIC SURGEONS SYRACUSE	NY	13210	
FALCONE, ALFRED E		2200 E. GENESEE ST, SUITE B SYRACUSE	NY	13210	
MORRISSEY, MICHAEL F	WESTCHESTER PLAS SURG ASSOC SUITE 712	45 LUDLOW STREET YONKERS	NY	10705	
WALDEN, RICHARD H., M.D.	LONG ISLAND PLAS SURGICAL GRP	999 FRANKLIN AVE. GARDEN CITY	NY	11530	

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
LEHMAN, JAMES A JR	PLASTIC & RECON SURGEONS INC	300 LOCUST STREET AKRON	OH	44302	
ARTZ J SHELDON	DINNER MELVYN I 3755 ORANGE PLACE	THE CENTER FOR PLASTIC SURG BEACHWOOD	OH	44122	
KAHL, JAMES B	MONTGOMERY N PLAS SURG CENTER 10545 MONTGOMERY ROAD	CINCINNATI	OH	45242	
MOHLER, LESTER R.	OHIO PLASTIC SURGEONS, INC	1100 MORSE ROAD COLUMBUS	OH	43229	
AVVA, SOMA S., MD	SOMA S. AVVA, MD INC SUITE 651	2200 PHILADELPHIA DR DAYTON	OH	45406	
HOUSER, ROBERT G.,MD	THE HOUSER OFFICE SURG.SUITE	480 S. CLEVELAND AVE. WESTERVILLE	OH	43081	
WOJTANOWSKI, MICHAEL H. MD	SURGIPLEX	950 CLAGUE RD. WESTLAKE	OH	44145	
BUKOVNIK, JOHN A	LAKE PLASTIC & RECONSTRUCTIVE 36100 EUCLID AVE.	SURGEONS, INC. WILLOUGHBY	OH	44094	
CINCINNATI PL. SGY. ASSOCIATES	ROBERT G. SLAGLE, M.D.	111 WELLINGTON PLACE CINCINNATI	OH	45219	

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                            FACILITY NAME                   ADDRESS
DIRECTOR'S NAME                   ADDRESS LN.2                        CITY            STATE ZIP CODE  CL

BAJAJ, PARAMJIT S. MD       CLASSEN PLASTIC SURGERY CENTER 1110 N. CLASSEN BLVD
                                                                 OKLAHOMA CITY         OK  73106


FORSYTHE, ROY L.            EDMOND PLASTIC SURGERY CENTER  1227 EAST NINTH STREET
                                                                 EDMOND                OK  73034


                            PLASTIC SURGERY ASSOCIATES, #1
MARTIN, FRED R.                   1725 EAST 19TH STREET STE 701  TULSA                 OK  74104
                            RAMEY, JR., PALMER R. MD.      PLASTIC SURGERY ASSOC. #2
CLARK, JOHN M. MD                 6585 S YALE AVE SUITE 1020     TULSA                 OK  74136
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DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CL
PARRISH EARL H MD	PLAS SURG ASSOC OF S.OREGON 786 STATE ST	EARL H PARRISH MD PC MEDFORD	OR	97504	
CARTER, BRUCE, MD	BRUCE CARTER, MD, P.C. SUITE 225	700 BELLEVUE ST., S.E. SALEM	OR	97301	

DIRECTOR'S NAME	FACILITY NAME ADDRESS LN.2	ADDRESS CITY	STATE	ZIP CODE	CI
APPAS, CHARLES E.	INST.FOR AESTHETIC PLASTIC SUR	467 PENNSYLVANIA AVE FT WASHINGTON	PA	19034	
AVIS, ROBERT M	DABB, RICHARD W	50 WYNTRE BROOKE DRIVE YORK	PA	17403	
KUNSKI, WLATER J., MD, FACS.	PLASTIC SRGY.CNTR OF ALLENTOWN	1210 S. CEDAR CREST BLVD.#2700 ALLENTOWN	PA	18103	
ATES, JAMES A., MD	PLASTIC SURGERY CENTER, LTD 205 GRANDVIEW AVE.	GRANDVIEW CORP PLACE,4TH FLOOR CAMP HILL	PA	17011	
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CKER, H A	ECKER PLASTIC SGY.ASSOC,INC.	420 WEST FOURTH STREET WILLIAMSPORT	PA	17701	
LOMAIN, ERIC W	N.E. PA PLASTIC SURGERY CENTER	1222 MARION STREET DUNMORE	PA	18509	

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1	VARGAS BUSQUETS, MIGUEL A.	INSTITUTO DE CIRUGIA PLASTICA		CALLE MENDEZ VIGO 165 ESTE	MAYAGUEZ	PR	00708	

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ROBER,    THOMAS L.III, M.D.    CAROLINA PLASTIC SURGERY           SUITE 100
                                      100 E. WOOD STREET                 SPARTANBURG               SC  29303
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IRECTOR'S NAME                FACILITY NAME                   ADDRESS
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ANDEIAN JOHN J. JR.           BRISTOL PLASTIC SURGERY CENTER 429 KINGSPORT HWY
                                                                   BRISTOL                  TN  37620
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                                   SUITE #900                      CHATTANOOGA              TN  37403
JOHNSON, RONALD J., MD        PLASTIC SGY GROUP OF MEMPHIS    6027 WALNUT GROVE
                                   SUITE 216                       MEMPHIS                  TN  38119
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MOORE, JEFF R.                GUERRA, CESAR H.                  HIGH PLAINS PLASTIC SGY CENTER
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PARKER, E RICHARD             GRANDVIEW SURGICAL CENTER         3316 GRANDVIEW AT 34TH
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MOSCOE, N. D.                 N.D. MOSCOE, M.D. ASSOC. O.R.     3705 MEDICAL PARKWAY
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                                                                       DALLAS               TX  75231
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                                     SUITE B145                        DALLAS               TX  75230
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                                     SUITE 120                         DALLAS               TX  75231
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                                     PLANO MEDICAL PARK                PLANO                TX  75075
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                                                                       PLANO                TX  75075
SWARTZ, BARRY F.              INSTITUTE FOR AESTHETIC            PLASTIC SURGERY
                                     4330 MEDICAL DRIVE, SUITE 400    SAN ANTONIO          TX  78229
STEPHENS, JOSEPH W., III, MD  STEPHENS O-PATIENT SURGI-CNTR     1000-B N. DAVIS DRIVE
                                                                       ARLINGTON            TX  76012
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GUNTER, JACK P., MD PA		8315 WALNUT HILL LN, SUITE 125 DALLAS	TX	75231	
ELBERT H. LEWIS, MD	LEWIS, E.H., MD & ASSOCIATES SUITE 104	3434 SWISS AVENUE DALLAS	TX	75204	
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FREDRICKS, SIMON	HOUSTON PLASTIC SURGERY ASSOC 6560 FANNIN	750 SCURLOCK TOWER HOUSTON	TX	77030	

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PICKENS, JAMESE., MD	PLAS., RECONST. & COSMETIC SGY	1002 EAST SOUTH TEMPLE SALT LAKE CITY	UT	84102	

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FRENCH, JAMES A., MD	THE CENTER FOR PLASTIC SURGERY SUITE 490	3299 WOODBURN RD. ANNANDALE	VA	22003	
SIEGEL, FRED A, MD, PC	 SUITE A	700 N. BATTLEFIELD BLVD. CHESAPEAKE	VA	23320	
SCHULER, III, FRANK A	HAMPTON ROADS PLASTIC 12515 WARWICK BLVD SUITE 301	SURGERY CENTER NEWPORT NEWS	VA	23606	
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SILBERBLATT, ENRIQUE A., MD	PLAS.,RECON, & HAND SURGERY PC SUITE 208	1030 S. JEFFERSON STREET ROANOKE	VA	24016	

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DICKASON, WAYNE L., MD	PLASTIC SURGICENTER OF OLYMPIA	400 LILLY ROAD, NE OLYMPIA	WA	98506	
SMITH, SHERWOOD P, MD	OLYMPIA PLASTIC SURGEONS, INC.	300-B LILLY RD NE OLYMPIA	WA	98506	
JACKSON, STANLEY M., MD		105 27TH AVE., S.E. PUYALLUP	WA	98374	
JAMES NORMAN J	WALCHAK FRANK R EAST 235 ROWAN #206	SPOKANE PLASTIC SURGEONS SPOKANE	WA	99207	
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HERNER, CARL F.	BELLEVUE PLASTIC SURGEONS	1551-116TH N.E. BELLEVUE	WA	98004	
NEU, BRUCE J /DUNDAS, DENNIS F	PLASTIC SURGERY NORTHWEST	13114 120TH NE KIRKLAND	WA	98034	
STURMAN, MELVIN J	PLAS & RECONS SURGEONS INC	17930 TALBOT ROAD SOUTH RENTON	WA	98055	
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RITSEFF, EDWARD L.	AESTHETIC PLASTIC SRGNS., INC SO. 19TH AND UNION AVE.	ALLENMORE MED. CNTR/STE #5010 TACOMA	WA	98405	
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LEIST, FREDERICK D.	OLYMPIC PLASTIC SURGERY ASSOC	2500 CHERRY AVENUE BREMERTON	WA	98310	

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HAMACHER, JOHN E MD           MIDWESTERN CENTER FOR COSMETIC  AND RECONSTRUCTIVE SURGERY
                                    20 S PARK ST                   MADISON                WI  53715
LEVY, DONALD M                CLINIC OF COSMETIC SURGERY     400 WEST SILVER SPRINGS DRIVE
                                                                   MILWAUKEE              WI  53217
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LEE, HANS, MD                 415 MORRIS STREET             SUITE 200
                                                                  CHARLESTON               WV  25301
POLACK, EDWARD R. MD          PLASTIC SURGERY, INC.         1300 CHAPLINE STREET
                                                                  WHEELING                 WV  26003
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101 W. University Avenue
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6301 NW 5th Way, Suite 4100
Ft. Lauderdale, FL 33309

CIGNA Healthplan of Arizona
4907 E. Broadway, Suite 100
Tucson, AZ 85711

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5826 N. 23rd Avenue
Phoenix, AZ 85021

CIGNA Healthplan of Florida
2502 Rocky Point Rd.
Suite 901
Tampa, FL 33634

CIGNA Healthplan of Texas
600 E. Las Colinas Blvd.
Suite 1100
Irving, TX 75038

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of California
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Glendale, CA 91203

Cincinnati Eye Insitute
10494 Montgomery Rd.
Cincinnati, OH 45242

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Health Association
2915 Clifton Ave.
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Colorado Springs, CO 80919

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Cleveland, OH 44106

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209 S. Nevada Avenue
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Duncanville, TX 75137

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73 Sandpit Road - Suite 101
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44139 Monterey Avenue
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Mansfield Professional Bldg
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1800 E. Meyer Blvd.
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29001 Cedar Road, Suite 500
Lyndhurst, OH 44124

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501 Doctors Court
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Plaquemine, LA 70764

Dow Chemical Company
Mich. Div. - Med. Dept.
4th St. & Buttles, 607 Bldg
Midland, MI 48667

Dow Chemical USA
Occupational Health Dept.
Texas Operations, B-101
Freeport, TX 77566

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Duluth, MN 55805

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1230 Johnson Ferry Rd.
Suite A-10
Marietta, GA 30067

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Eye Institute of Essex
80 Newark Avenue
Belleville, NJ 07109

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410 W. Chestnut Street
Lincoln Fed. Bldg., Suite 9
Louisville, KY 40202

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23961 Calle de la Magdalena
Suite 117
Laguna Hills, CA 92653

Eye Clinic Ambulatory
Surgical Center
601-605 Wyoming Avenue
Kingston, PA 18704

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503 Doctor's Court
Oshkosh, WI 54901

Eye Institute of
Southern Arizona, PC
5632 E. 5th Street
Tucson, AZ 85711

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755 East 3900 South
Salt Lake City, UT 84124

Eye Physicians Medical/
Surgical Center, Inc.
681 Third Avenue
Chula Vista, CA 92010

Eye Surgery Center
2802 Ross Clark Circle
Dothan, AL 36301

Facial Plastic &
Cosmetic Surgery Center
133 Barnwood Drive
Edgewood, KY 41017

Facial Plastic and Cosmetic
Surgical Center
6300 Humana Plaza
Abilene, TX 79606

Facial Plastic Surgery
Center, Inc.
777 37th, Suite C-101A
Vero Beach, FL 32960

Facial Plastic Surgery, P.S
S7008 Allenmore Medical Ctr
Tacoma, WA 98405

Fairfax Surgical Center
10730 Main Street
Fairfax, VA 22030

Fairless Hills Medical Ctr
515 South Oldes Avenue
Suite 301
Fairless Hills, PA 19030

Family Birthing Center
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3838 Sherman Drive - Suite
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Family Dental Services
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5361 N.W. 22nd Avenue
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1781 Metro Medical Drive
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2801 K Street, Suite 525
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University of Arkansas
800 Razorback Road
Fayetteville, AR 72701

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Surgery Center, Suite 421
11160 Warner Avenue
Fountain Valley, CA 92708

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1040 Delaware Avenue
Marion, OH 43302

Fredericksburg Ambulatory
Surgery Center
2216 Princess Anne Street
Fredericksburg, VA 22401

Fresno Surgery Center
6125 N. Fresno Street
Fresno, CA 93710

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17752 Beach Blvd.
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Fronske Health Center
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Flagstaff, AZ 86011

Frost Street Outpatient
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8008 Frost St., Suite 200
San Diego, CA 92123

Gary Hall Eye Surgery
Institute
2501 N. 32nd St.
Phoenix, AZ 85008-2104

Geauga Eye Surgery
12793 Taylor Wells Street
Chardon, OH 44024

Gene E. Myers, MD, PA
2121 S. Tamiami Trail
Sarasota, FL 33579

Gert E. Pokorny, M.D.,
FACOG, Inc.
515 South Drive, Suite 24
Mountain View, CA 94040

Gould Medical Foundation
600 Coffee Road
Modesto, CA 95355

Greater Sacramento Surgery
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3301 Del Paso Blvd.
Sacramento, CA 95815

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2251 DuBois Drive
Warsaw, IN 46580

Group Health Cooperative of
South Central Wisconsin
One S. Park Street
Madison, WI 53715

Grove Avenue Surgical Suite
3915 Grove Ave
Richmond, VA 23221

Grove Dental Associates
6600 South Main Street
Suite 315
Downers Grove, IL 60516

Halifax Hospital Med. Ctr.
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303 N. Clyde Morris Blvd.
Daytona Beach, FL 32015

Hamilton Medical Group, P.C
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Lafayette, LA 70506

Hampton Roads Plastic
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12515 Warwick Blvd, #301
Newport News, VA 23606

Hartford Surgical Center
100 Retreat Avenue
Hartford, CT 06106

Havasu Outpatient Surgery C
151 Riviera Drive
Lake Havasu City, AZ 86403

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Student Health Service
Haverford, PA 19041

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606 Kilani Avenue
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Los Angeles, CA 90045

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1500 Dodson Avenue
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2025 E. 17th St.
Idaho Falls, ID 83401

Illinois State University
Student Health Service
Dry Grove & University
Normal, IL 61761

Indiana University
Student Health Service
600 North Jordan
Bloomington, IN 47401

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361 N. San Jacinto Street
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225 Abraham Flexner Way
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6750 Hillcrest Plaza Drive
Suite 215
Dallas, TX 75230

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Lake Charles, LA 70601

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103 Fair Drive
Susanville, CA 96130

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Salem, VA 24153

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110 Willis Avenue
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11111 Nall Suite 202
Leawood, KS 66211

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4111 S. 40th St. - Suite 9
Phoenix, AZ 85040

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Oklahoma City, OK 73140

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1000 Langworthy
Dubuque, IA 52001

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2374 Nicholasville Rd.
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18799 Lakeshore Boulevard
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360 E. H. Crump Blvd.
Memphis, TN 38126

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6660 Coyle Avenue
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Bakersfield, CA 93301

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The Dalles, OR 97058

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Mobile, AL 36606

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1515 Tenth Street
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Montana State University
Swingle Student Hlth Svc
Bozeman, MT 59717

Monterey Peninsula
Surgical Associates
966 Cass Street, Suite 210
Monterey, CA 93940

Nalle Clinic
1350 S. Kings Drive
Charlotte, NC 28207

Naugatuck Valley Surgical
Center
160 Robbins Street
Waterbury, CT 06708

Nicolet Clinic, S.C.
411 Lincoln Street
Neenah, WI 54956

Norbert F. Czajkowski,
M.D., P.C.
33080 Utica Rd
Fraser, MI 48026

Norfolk Diagnostic Clinic,
850 Kempsville Road
Norfolk, VA 23502

Norte Vista Medical
Center, Ltd.
2410 North Fowler
Hobbs, NM 88240

North Denver Surgical Ctr
10001 N. Washington
Thornton, CO 80229

Northbank Surgical Center
700 Bellevue Street, South
Suite 300
Salem, OR 97301

Northern Arizona Eye
Clinic, Ltd.
900 N. San Francisco
Flagstaff, AZ 86001

Northern Ill University
Health Services
Wirtz Drive West
DeKalb, IL 60115

Northpoint Dental Group,Ltd
2315 N. Lake Drive
Milwaukee, WI 53211

Northway Surgicenter, Inc.
1555 Northway Drive
St. Cloud, MN 56301

Northwest Eye Center, P.C.
1700 Valley River Road
Eugene, OR 97401

Northwest Ohio Urologic
Sciences, Inc.
5930 Huntingfield Blvd.
Toledo, Oh 43615

Northwest Surgicare, Ltd.
1100 West Central Road
Arlington Heights, IL 60005

Nova Surgicenter, Inc.
120 S. Spalding Dr.-S#205
Beverly Hills, CA 90212

Ochsner Clinic
1514 Jefferson Highway
New Orleans, LA 70121

Ohio Eye Associates, Inc.
Eye Surgery Center
466 S. Trimble Road
Mansfield, OH 44906

Oklahoma City Clinic
701 Northeast 10th Street
Oklahoma City, OK 73104

Old Dominion University
Student Health Services
1800 Parker Street
Norfolk, VA 23508-8573

Olmsted Medical & Surgical
210 Ninth Street, S.E.
Rochester, MN 55904

Olympic Ambulatory
Surgery Center
2601 Cherry Street
Bremerton, WA 98310

One Day Surgery Center
325 W. Lincoln Street
Belleville, IL 62221

Orange Surgical
Services, Inc.
302 W. LaVeta Ave., #100
Orange, CA 92666

Outpatient Surgery
Center, Inc.
450 N. New Ballas Rd, S#103
Creve Coeur, MO 63141

Outpatient Surgical Center
Medical Arts Center
Suite F
Blacksburg, VA 24060

Owensboro Surgery
Center, Inc.
1100 Walnut
Owensboro, KY 42301

Palo Alto Medical Clinic
300 Homer Avenue
Palo Alto, CA 94301

Palo Alto Surgecenter/dba
Surgecenter of Palo Alto
400 Forest Avenue
Palo Alto,, CA 94301

Park Dental Health Centers
6415 Brooklyn Boulevard
Brooklyn Center, MN 55429

Park DuValle Community
Health Center
1817 South 34th Street
Louisville, KY 40211

Park Nicollet Medical Cente
5000 W. 39th Street
Minneapolis, MN 55416

Paul H. Goodman, MD
4048 Third Ave., Suite 202
San Diego, CA 92103

Peninsula Amb. Plstc S. C.
12420 Warwick Blvd
Building One, Suite F
Newport News, VA 23606

Peninsula Obstetrics &
Gynecology, PA
314 W. Carroll Street
Salisbury, MD 21801

Perkins Facial Plastic
Surgery, P.C.
8128 Knue Road, Suite 103
Indianapolis, IN 46250

Physicians Surgical Center
805 East Robinson
Norman, OK 73071

Pikeville Surgical
Center, Inc.
261 Town Mountain Road
Pikeville, KY 41501

Plastic & Reconstructive
Surgery, PA
828 N. Hillside
Wichita, KS 67214

Plastic Surgery Associates
of Lynchburg
1330 Oak Lane - Suite 100
Lynchburg, VA 24503

Plaza Surgery Center
201 N.W. 82nd Ave.,S#304
Plantation, FL 33324

Pomerado Outpatient
Surgical Center
15525 Pomerado Road, E-2
Poway, CA 92064

Prescott Outpt Surg. Ctr
815 Ainsworth Drive
Prescott, AZ 86301

Primacare Medical Centers
12170 Abrams Rd. #220
Dallas, TX 75243

Princeton University
Health Services
Isabella McCosh Health Ctr.
Princeton, NJ 08544

Radamerica, Inc.
White Square Prof. Bldg.
9015 Franklin Square Drive
Baltimore, MD 21237

Redwood Medical Clinic
2900 Whipple Avenue
Redwood City, CA 94062

Reynolds Health Center
741 Highland Avenue
Winston-Salem, NC 27101

Richburg Valley Eye Inst.
1680 E. Herndon
Fresno, CA 93710

Riverside Medical Clinic
Surgery Center
7160 Brockton Avenue
Riverside, CA 92506

Rocky Mountain
Surgery Center
2405 Broadway
Boulder, CO   80302

Roseland Surgical Center
556 Eagle Rock Avenue
Roseland, NJ   07068

Ross Valley Medical Clinic
1350 S. Eliseo Drive
Greenbrae, CA   94904

Saddleback Valley
Outpatient Surgery
24302 Paseo de Valencia
Laguna Hills, CA   92653

Salt Lake Clinic
333 S. 900 East
Salt Lake City, UT   84102

Samaritan Health Service
1410 N. Third Street
Phoenix, AZ   85004

Same Day Surgicare of
  New England, Inc.
272 Stanley Street
Fall River, MA   02720

San Antonio Eye Surgicenter
800 McCullough
San Antonio, TX   78215

San Gabriel Valley
 Surgical Center, Inc.
1250 S. Sunset Av., Ste 100
West Covina, CA   91790

San Jose State University
Student Health Services
1 Washington Square
San Jose, CA   95192-0037

Santa Cruz Medical Clinic
2025 Soquel Ave
Santa Cruz, CA   95062

Santa Cruz Surgery Center
3003 Salisbury Avenue
Santa Cruz, CA   95065

Scott and White Clinic
2401 South 31st Street
Temple, TX   76508

Scripps Clinic & Research
Foundation
10666 N. Torrey Pines
La Jolla, CA   92037

Sharp-Rees-Stealy
Medical Group
2001 Fourth Avenue
San Diego, CA   92037

Sheboygan Clinic
2414 Kohler Memorial Drive
Sheboygan, WI   53081

Shepherd Eye Surgicenter
3196 Maryland Parkway
Suite 309
Las Vegas, NV   89109

Sioux Falls Surgical Center
910 E. 20th Street
Sioux Falls, SD   57105

Smith-Glynn-Callaway
  Clinic, Inc.
3231 S. National
Springfield, MO   65804

South Temple Surgical
 Corporation
702 E. South Temple, Ste.
Salt Lake City, UT   84102

South Texas Surgicare Ctr
1327 Third Avenue
Corpus Christi, TX   78404

Southern Plains Medical Ctr
2222 Iowa Avenue
Chickasha, OK   73018

Southwestern Ambulatory
Facilities Corp.
1111 Sonoma Avenue
Santa Rosa, CA   95405

Specialists' Ambulatory
Surgery Center
9001 Wilshire Blvd #200A
Beverly Hills, CA   90211

Springfield Clinic
1025 S. Seventh Street
Springfield, IL   62703

St. Cloud Orthopedic
Associates, Ltd.
1555 Northway Drive
St. Cloud, MN   56301

St. Cloud Surgical Center
1401 St. Germain
St. Cloud, MN 56301

St. Louis Comprehensive
Health Center, Inc.
5471 Dr.MartinLutherKing Dr
St. Louis, MO 63112

St. Petersburg Med. Clinic
1099 5th Ave., N.
St. Petersburg, FL 33705

Stanford University
Clinic
300 Pasteur Dr.- Rm A251
Stanford, CA 94305

Stephen B. Anderson, MD, PS
1632 116th NE, Suite A
Bellevue, WA 98004

Stockton Eye Surgery Center
36 W. Yokuts Ave., Suite 3
Stockton, CA 95207

Straub Clinic and Hospital
888 S. King Street
Honolulu, HI 96813

Stuart Institute for
Eye Surgery
2090 S.E. Ocean Blvd
Stuart, FL 34996

Summit Medical Group, P.A.
120 Summit Avenue
Summit, NJ 07901

Summit Surgical Center
110 Carnie Blvd.
Voorhees, NJ 08043

Surgery Center
2761 Sullins Center
Knoxville, TN 37919

Surgery Center of Des Moine
1301 Pennsylvania Avenue
Suite 100
Des Moines, IA 50316

Surgery Center of Physician
Medical Group, Inc.
6840 Sepulveda Blvd.
Van Nuys, CA 91405

Surgi-Center of Winchester
1860 Amherst Street
Winchester, VA 22601

Surgi-Eye Center
7012 Reseda Boulevard
Suite D
Reseda, CA 91335

Surgical Center
of Greensboro
1211 Virginia Street
Greensboro, NC 27401

Surgical Recovery Center
340 E. Coronado
Phoenix, AZ 85004

Surgicare of Tulsa
4415 South Harvard
Suite 100
Tulsa, OK 74135

Surgicare of Wichita
810 N. Lorraine Street
Wichita, KS 67214

Surgicenter of San Antonio
7902 Ewing Halsell Drive
San Antonio, TX 78229

Surgicenter, Inc.
1040 E. McDowell Road
Phoenix, AZ 85006

Sutter Surgery Center
75 Scripps Drive
Sacramento, CA 95825

Tacoma Ambulatory
Surgery Center
918 Sixth Ave., Suite B
Tacoma, WA 98405

Tampa Surgi-Center
4500 E. Fletcher Avenue
Tampa, FL 33612

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Temple Surgical Center
60 Temple Street
New Haven, CT 06510

Texas Outpatient
Surgicare Center
17080 Red Oak Drive
Houston, TX 77090

Thomas Davis Med. Ctrs, PC
630 N. Alvernon Way
Tucson, AZ 85711

Toledo Clinic, Inc.
4235 Secor Road
Toledo, OH 43623

Trover Clinic
Clinic Drive
Madisonville , KY 42431

Troy Obstetrics &
Gynecology, PC
1565 W. Big Beaver, Bldg F
Troy, MI 48084

Univ. of South Carolina
Thomson Student Health Ctr
Columbia, SC 29208

University of Arizona
Student Health Service
Cherry & University Blvd.
Tucson, AZ 85721

University of California
Student Health Service
Irvine, CA 92717

University of Connecticut
Student Health Service
U-11 Glenbrook Rd.
Storrs, CT 06268

University of Massachusetts
University Health Services
Amherst, MA 01003

University of MD Health Ctr
Campus Drive
College Park, MD 20742

University of MD-Baltimore
County Student Health Svcs
Baltimore County Campus
Baltimore, MD 21228

University of Minnesota
Boynton Health Service
410 Church Street, S.E.
Minneapolis, MN 55455

University of N. Colorado
Student Health Service
Decker Hall, 19th Street
Greeley, CO 80639

University of Nebraska
Health Center
15th & University Streets
Lincoln, NE 68588

University of Oregon
Student Health Center
1590 E. 13th Street
Eugene, OR 97403

University of South Dakota
Student Health Service
414 East Clark
Vermillion, SD 57069

University of Washington
Hall Health Center
Stevens Way
Seattle, WA 98195

University of Wisconsin
University Health Service
1552 University Avenue
Madison, WI 53705

University of Wyoming
Student Health Center
Health Nursing Building
Laramie, WY 82071

Upland Outpatient
Surgical Center
1330 San Bernardino Road
Upland, CA 91786

Valley Eye Center, P.A.
2001 Ed Carey Drive
Harlingen, TX 78550

Valley Eye Clinic & Outpatient Surgery Center, PA
1515 N. Ed Carey Drive
Harlingen, TX 78550

Valley Hand Surgery Center
14624 Sherman Way, Ste. 306
Van Nuys, CA 91405

Venice Same Day Surgery,Inc
950 Cooper Street
Venice, FL 33595

Virginia Eye Institute
400 W. Hampton Station
Richmond, VA   23226

Walk In & Out Surgery
Center, Inc.
383 Bogle Street
Somerset, KY   42501

Walrose Reconstructive
Surgery Center
125 W. Walnut
Kalamazoo, MI   49007

Watkins Health Center
University of Kansas
Student Health Service
Lawrence, KS   66045

Watson Clinic
1600 Lakeland Hills Blvd.
Lakeland, FL   33805

Watts Health Foundation
10300 South Compton Avenue
Los Angeles, CA   90002

West Oakland Ambulatory Car
Care Center
1885 North Pontiac Trail
Walled Lake, MI   48088

West Reading Ophthalmic
Associates
206 S. Sixth Avenue
West Reading, PA   19611

West Virginia Eye Surgery
Center
425 Greenway Street
S. Charleston, WV   25309

Wheeling Clinic
58 Sixteenth Street
Wheeling, WV   26003

Wichita Falls Clinic
501 Midwestern Parkway, E.
Wichita Falls, TX   76302

Winston Salem Dental
Care Plan
201 Charlois Boulevard
Winston-Salem, NC   27103

Winston-Salem Health
  Care Plan, Inc.
250 Charlois Boulevard
Winston-Salem, NC   27103

Zeiter Eye Clinic Surg. Cen
117 N. San Joaquin Street
Stockton, CA   95202

April 14, 1989 M8:59

AAAAPSF
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AAAAPSF ACCREDITATION OFFICE

American Association for Accreditation
of Ambulatory Plastic Surgery Facilities, Inc.
1202 ALLANSON ROAD
MUNDELEIN, ILLINOIS 60060
Phone: (312) 949-6058

INSPECTION
AND
ACCREDITATION
PROGRAM

AMERICAN ASSOCIATION for ACCREDITATION of
AMBULATORY PLASTIC SURGERY FACILITIES, INC.

• A PROGRAM OF IMPROVEMENT •

The American Association for Accreditation of Ambulatory Plastic Surgery Facilities invites you to participate in the voluntary program of inspection and accreditation of your plastic surgery facility.

HISTORY

The AAAAPSF was formed in October 1980 to provide an objective evaluation for recognition of professionally operated plastic surgery facilities meeting the standards established by the Association. The AAAAPSF is a nonprofit association and chartered as an IRS 501-C6 Corporation.

DEFINITION AND ELIGIBILITY

A plastic surgery facility eligible for voluntary inspection and accreditation is a facility which is operated under the direction of a plastic surgeon who is certified by the American Board of Plastic Surgery.

BENEFITS OF THE PROGRAM

- *Verification of excellence*
- *Improvement of state-of-the-art*
- *Personnel recognition, improvement and justification*
- *Provision of quality through adherence to nationally recognized standards*
- *Referrals of accredited facilities*
- *Regulatory and legislative activity*
- *3rd party reimbursement negotiations*

WHAT ACCREDITATION MEANS TO YOU AND YOUR PROFESSION

The inspection and accreditation process certifies to the medical community and the community at large that the surgery facility meets the nationally recognized standards through an accreditation program operated by the experts who set and evaluate the standards . . . plastic surgeons certified by the ABPS.

HOW TO INITIATE THE INSPECTION PROCESS

Mail the application form and your check in the amount of $350.00 (Class A) or $450.00 (Class AB and ABC) to the AAAAPSF Inspection and Accreditation Office, 505 E. Hawley Street, Mundelein, Illinois 60060. The Inspection and Accreditation Office will mail you a questionnaire and a copy of the standards and checklist which will be used during the inspection. If you already have the checklist/questionnaire, complete sections I and II and forward it along with your check and this application.

WHO WILL INSPECT YOUR FACILITY?

Through peer evaluation, the facility and its personnel will undergo a continuing education process toward the overall improvement of your practice. The experts conducting the inspection understand the profession, its needs and its desire for improvement. The experts are plastic surgeons, Board Certified by ABPS, and who operate accredited facilities themselves.

The Inspectors will be selected from your region preferably not from your local community. You will be advised of a list of potential inspectors prior to the inspection date — you have the right to veto Inspector selection three times. Inspectors are volunteers and are not compensated.

ACCREDITATION CYCLE

Accreditation will be on a three-year cycle. The facility will be expected to maintain the standards of the Association in the interim years. A self-inspection shall be performed during the interim years and the computer evaluation shall be for your use and information only.

The fee for the accreditation cycle is $1,350 payable over three years at $450 per year or a one time fee of $1,200 upon application for Class AB and ABC. The fee is $1,050 payable over three years at $350 per year or a one time fee of $900 upon application for a Class A facility. This fee covers the cost of development, processing the Checklist each year, administration of the manuals and Checklist used in the program.

CLASS DEFINITIONS

Class A: Performed under local, regional, or topical anesthesia; applies to minor plastic surgical procedures.

Class B: Performed under intravenous or parenteral sedation, analgesia or dissociative drugs; applies to minor or major plastic surgical procedures.

Class C: Major plastic surgery procedures performed under general anesthesia with external support of vital body functions.

Please check your facility class ☐ A
☐ B
☐ C

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY PLASTIC SURGERY FACILITIES

• APPLICATION FOR INSPECTION •

Please complete and mail with your check in the amount of **$450.00** *for Class AB and ABC, and* **$350.00** *for Class A (for 1st year) to the AAAAPSF Inspection & Accreditation Office: 1202 Allanson Road, Mundelein, IL 60060. Phone: 312-949-6058*

Please print or type

Facility Director ____________________ State License No. ____________________

Name of Facility ____________________ Street Address ____________________

City, State, Zip Code ____________________ Tel. Area Code-Number Extension ____________________

Accreditation Association for Ambulatory Health Care, Inc.

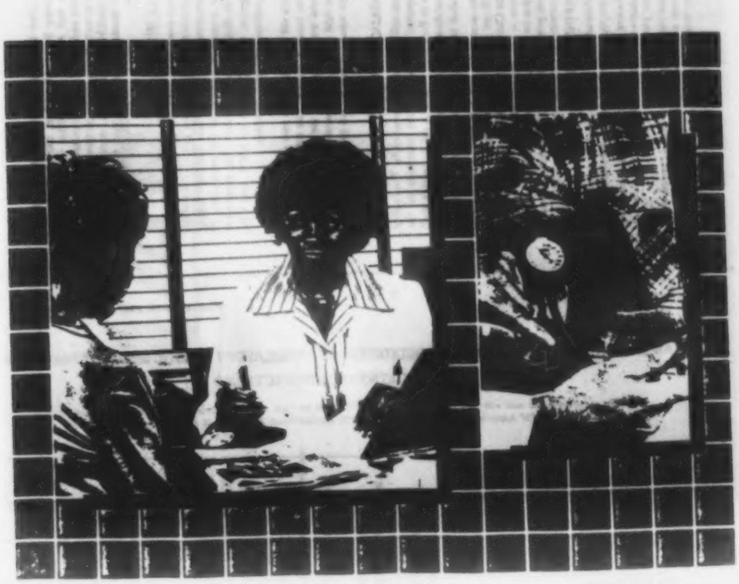
"The accreditation process was a great educational experience. We learned more about ourselves than we thought possible. We found the people who actually did the survey were very knowledgeable and extremely helpful. The dialogue during their visit assisted us greatly in improving our services."

Clifford Harris M.D.
Southwest Division Medical Director
CIGNA Healthplan of Arizona

The AAAHC is the principal accreditation program with nationally recognized standards for ambulatory health care organizations. Incorporated in 1979, AAAHC is the successor program to four separate accreditation or certification programs begun in the late 1960's.

AAAHC is committed to helping HMOs and other ambulatory health care organizations improve the quality of care they provide to patients while helping to minimize duplicative and unnecessary regulatory reviews. AAAHC accredits health plans, provider groups within plans, and service networks which contract with plans. All types of prepaid plans are eligible for AAAHC accreditation.

Over 90 different HMOs use organizations currently accredited by AAAHC. **More than 1.5 million enrollees are served by over 6,000 physicians working in AAAHC accredited organizations.**



> *"As a surveyor of numerous HMO plans I know the process has been beneficial and educational to those surveyed. The peer based nature of the program enables surveyors to provide an invaluable service without accompanying red tape or bureaucratic process. In all instances, the organizations indicated the suggestions made by the surveyors helped them improve services to their members."*
>
> **Barry Averill, Executive Director**
> **Michael Reese Health Plan**

The Accreditation Process for HMOs

The accreditation process begins with a comprehensive self-assessment by the HMO using AAAHC guidelines. Self-evaluation not only prepares the organization for the accreditation survey, but also aids in the discovery of an organization's strengths and weaknesses. Workshops on the standards, as well as on-site consultation surveys are available to HMOs upon request.

Following self-assessment and completion of pre-survey documents, an on-site survey is conducted by a team of physicians, administrators and other health care professionals who actively practice in HMOs. These surveyors are volunteers who serve without pay because they are committed to high quality health care.

The role of the surveying team extends beyond evaluation of an HMO's compliance with AAAHC standards. Special emphasis is given to review of the care provided, medical records, and the HMO's quality assurance and risk management programs. The surveyors also consult with and advise HMO providers on ways to improve the quality of care and efficiency of operations. This interaction provided by AAAHC's unique peer-review system is the key to its unparalleled acceptance by both large and small plans.

The AAAHC Board of Directors, which is also composed of peer group volunteers, renders a final accreditation decision based on the surveyors' report and other information gathered in the survey process.

The Standards

AAAHC standards have been developed over a 20 year period by individuals representing the highest level of achievement in medical practice and administrative expertise. They are by definition dynamic, changing as the profession changes to reflect the highest levels of care which can be achieved.

The standards address such areas as quality of care; quality assurance; medical records; professional and technical services; as well as governance, administration, and professional development. They are published in the *Accreditation Handbook for Ambulatory Health Care.*

Accreditation Advantages for HMOs

Because of the self-evaluation and peer-review systems developed by AAAHC, HMOs welcome AAAHC surveys as constructive learning experiences. The resulting benefits to HMOs include improved quality of care, quality assurance and risk control as well as effective and efficient management.

Employees and union representatives are considering accreditation to assist them in the evaluation of HMOs. Government agencies have also recognized the value of AAAHC accreditation, and some professional liability insurance carriers extend premium credits and discounts to AAAHC accredited organizations.

An Ongoing Commitment

The HMOs which request AAAHC accreditation share our goal of improving the quality of health care. The HMOs which are awarded AAAHC accreditation view it as part of their ongoing commitment to quality, and not just as an accomplished fact.

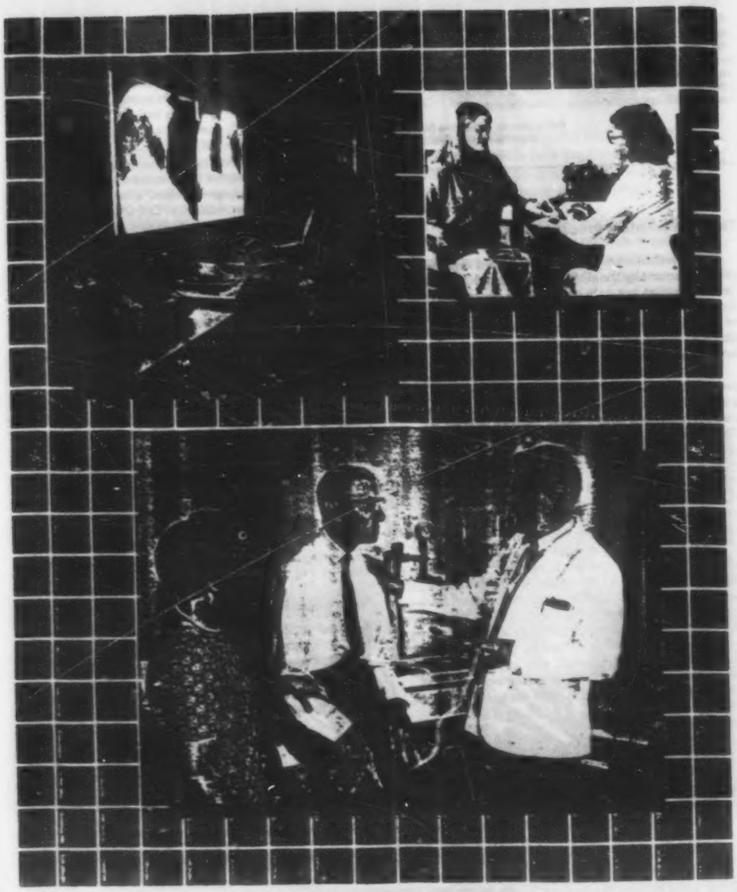
AAAHC Member Organizations

The following national groups are AAAHC sponsoring organizations: American Academy of Facial Plastic and Reconstructive Surgery, American College Health Association, American Group Practice Association, American Society of Outpatient Surgeons, Federated Ambulatory Surgery Association, Medical Group Management Association, National Association for Ambulatory Care, National Association of Community Health Centers, Outpatient Ophthalmic Surgery Society.

For more information, contact:

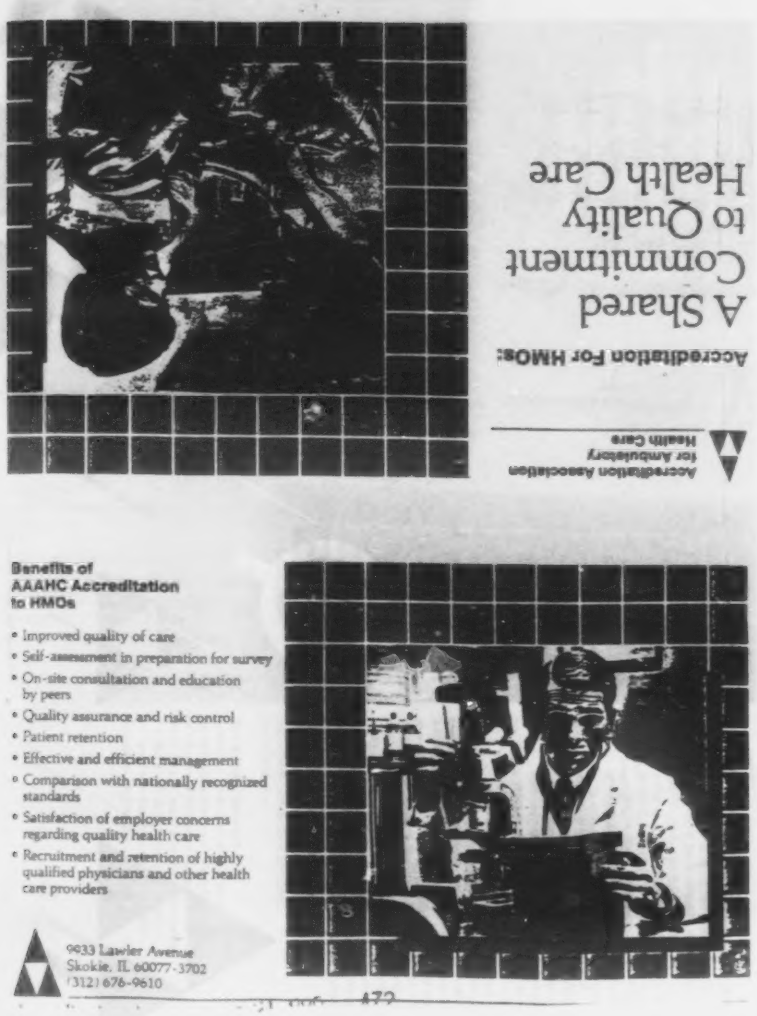
Accreditation Association
for Ambulatory
Health Care, Inc.
9933 Lawler Avenue
Skokie, IL 60077-3702
(312) 676-9610

> *"We appointed a task force to review the AAAHC standards and were impressed with the thoroughness of the survey process and the survey team members. It reinforced our perception for the need to have an outside, objective body review the workings of our HMO with an unbiased assessment. The survey process gave us an opportunity to measure ourselves against nationally recognized standards."*
>
> **Patrick Brady, Executive Director**
> **Group Health Cooperative of South Central Wisconsin**



"Our medical group believes in voluntary accreditation by AAAHC. It has improved the quality of our medical care and provided the incentive to give that extra measure of attention which places an "accredited" medical group above the standards of the community."

John McSweeney, MD, Medical Director
Cincinnati Group Health Association
Cincinnati, Ohio



Accreditation Association for Ambulatory Health Care

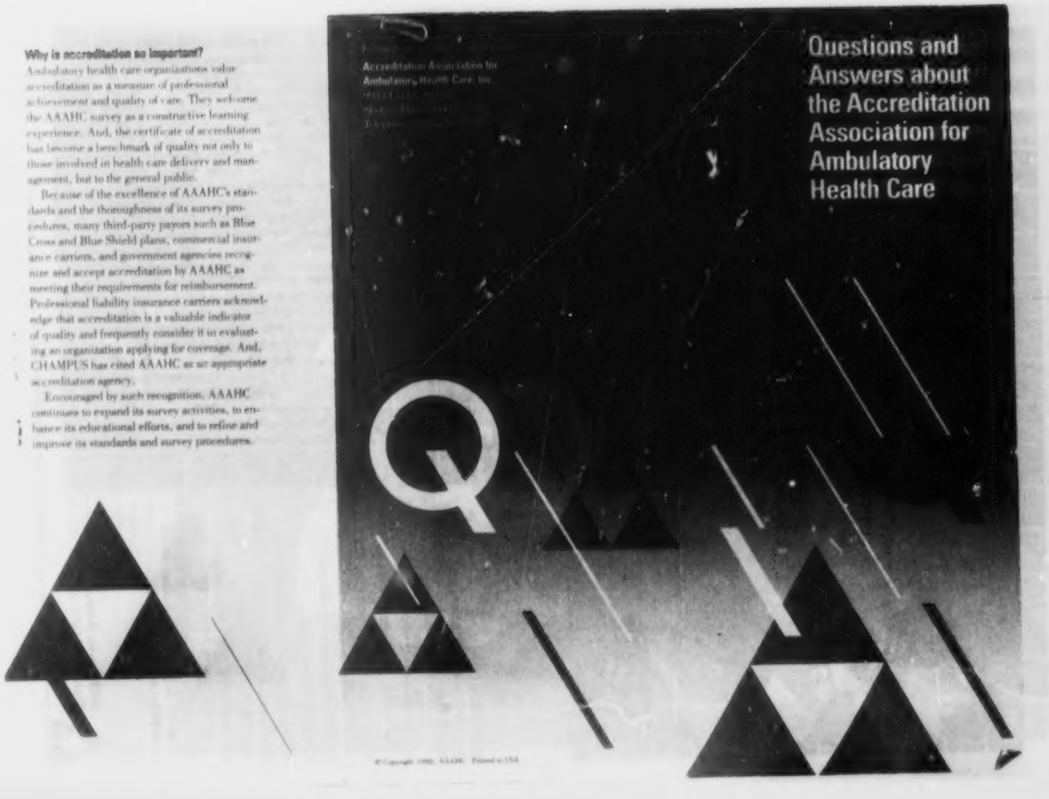
Accreditation For HMOs:

A Shared Commitment to Quality Health Care

Benefits of AAAHC Accreditation to HMOs

- Improved quality of care
- Self-assessment in preparation for survey
- On-site consultation and education by peers
- Quality assurance and risk control
- Patient retention
- Effective and efficient management
- Comparison with nationally recognized standards
- Satisfaction of employer concerns regarding quality health care
- Recruitment and retention of highly qualified physicians and other health care providers

9933 Lawler Avenue
Skokie, IL 60077-3702
(312) 676-9610



Why is accreditation so important?

Ambulatory health care organizations value accreditation as a measure of professional achievement and quality of care. They welcome the AAAHC survey as a constructive learning experience. And, the certificate of accreditation has become a benchmark of quality not only to those involved in health care delivery and management, but to the general public.

Because of the excellence of AAAHC's standards and the thoroughness of its survey procedures, many third-party payors such as Blue Cross and Blue Shield plans, commercial insurance carriers, and government agencies recognize and accept accreditation by AAAHC as meeting their requirements for reimbursement. Professional liability insurance carriers acknowledge that accreditation is a valuable indicator of quality and frequently consider it in evaluating an organization applying for coverage. And, CHAMPUS has cited AAAHC as an appropriate accreditation agency.

Encouraged by such recognition, AAAHC continues to expand its survey activities, to enhance its educational efforts, and to refine and improve its standards and survey procedures.

Accreditation Association for
Ambulatory Health Care, Inc.

Questions and Answers about the Accreditation Association for Ambulatory Health Care

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What is the Accreditation Association for Ambulatory Health Care?

The AAAHC is a private, not-for-profit organization that was formed in 1979 to assist ambulatory health care organizations in improving the quality of care they provide to their patients. It accomplishes this by setting standards, measuring performance, providing consultation and education where needed, and ultimately by awarding accreditation to those organizations that are found to be in compliance with its standards.

What is accreditation?

Accreditation is a voluntary process through which an ambulatory health care organization is able to measure the quality of its services and performance against nationally recognized standards. The accreditation process involves self-assessment by the organization as well as a thorough review by AAAHC's expert surveyors who are themselves practicing health care professionals.

The accreditation certificate is a symbol to others that an organization is committed to providing high-quality care and that it has demonstrated its commitment by measuring up to AAAHC's high standards. The true value of accreditation, however, lies in the consultative and educational process that precedes the awarding of the certificate. It is the self-analysis, peer review, and consultation that ultimately helps an organization improve its care and services.

What are standards?

The standards, published in the *Accreditation Handbook for Ambulatory Health Care*, describe organizational characteristics that AAAHC believes are essential to high-quality patient care. They relate to such areas as quality of care and quality assurance activities, medical records, clinical and pharmaceutical services, environmental safety, governance, administration, and professional development.

The standards have been developed over a period of more than 20 years by individuals representing the highest levels of achievement in clinical practice and health care management. The standards are by definition dynamic and changing as medicine and health care change to reflect the highest levels of care.

Who decides whether an organization is accredited?

Before accreditation is awarded, an organization participates in a thorough multi-step evaluation process. The basic elements of the process are a self-assessment completed by the organization itself and an on-site survey conducted by a team of physicians, health care managers, and other health professionals who actively practice in organizations similar to those AAAHC surveys. All surveyors are volunteers, serving without pay because they believe in promoting high-quality ambulatory health care.

The AAAHC board of directors – another volunteer group of health care professionals – renders the final accreditation decision based on the surveyors' findings and other information gathered during the survey process. Accreditation may be awarded for either one or three years, depending on the level of compliance with the standards.

Who makes up the board of AAAHC?

The physicians and health care executives who sit on the AAAHC board are appointed by eleven of the nation's leading health care associations: American Academy of Dental Group Practice, American Academy of Facial Plastic and Reconstructive Surgery, American College Health Association, American Group Practice Association, American Occupational Medical Association, American Society of Outpatient Surgeons, Federated Ambulatory Surgery Association, Medical Group Management Association, National Association for Ambulatory Care, National Association of Community Health Centers and Outpatient Ophthalmic Surgery Society.

What kinds of organizations seek accreditation?

AAAHC has conducted surveys in nearly every type of ambulatory health care organization including: ambulatory clinics and surgery centers, single- and multi-specialty group practices, health maintenance organizations, birthing centers, college and university health services, faculty medical practices, community health centers, hospital-sponsored ambulatory health services, urgent and immediate care centers, office-based surgery centers and practices, and networks and groups of ambulatory care organizations.

How is AAAHC financed?

Funding for AAAHC comes from fees paid by surveyed organizations and contributions made by the national associations that make up the board. AAAHC receives no government funding. It is able to maintain its extensive activities because of its volunteer surveyors and leadership and its administrative efficiency.

FACIAL
PLASTIC
SURGERY™

AMERICAN ACADEMY OF FACIAL PLASTIC
AND RECONSTRUCTIVE SURGERY, INC.

March 10, 1989

Representative Ron Wyden, Chairman
Subcommittee on Regulation and
Business Opportunities
B-363 Rayburn Building
Washington, DC 20515

Dear Rep. Wyden:

At your request, I am happy to enclose a copy of the Academy's position paper on accreditation for ambulatory health care facilities.

I've enjoyed working with Frank Papineau on this hearing and look forward to testifying in April.

Please let me or the Academy's Executive Vice President Lee VanBremen know if we can be of assistance in any other way.

Sincerely,

Ted A. Cook

Ted A. Cook, M.D.
Secretary

Enclosure: Position of AAFPRS on Accreditation for Ambulatory Healthcare Facilities

kjl

1101 Vermont Ave., N.W.
Suite 404
Washington, D.C. 20005
202/842-4500

POSITION OF AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY ON ACCREDITATION FOR AMBULATORY HEALTHCARE FACILITIES

The American Academy of Facial Plastic and Reconstructive Surgery is a national specialty society of board-certified surgeons performing facial plastic surgery. The Academy is a constituent specialty society of the American Medical Association. The Academy's bylaws require that its Fellows be Fellows of the American College of Surgeons and certified by one of the boards recognized by the American Board of Medical Specialties.

The Academy believes that the following principles should guide accreditation of ambulatory healthcare facilities:

The Lodestar: Patient/Consumer Welfare

The Academy believes that patient and consumer welfare should form the lodestar of decisions about ambulatory healthcare facilities. Such patient and consumer welfare requires two things: (1) high professional standards and (2) choices in the marketplace among qualified surgeons. High standards benefit patient/consumers by assuring them that their surgeons and those surgeons' facilities will be safe. Choices in the marketplace among qualified surgeons benefit patient/consumers by saving them from the tyranny of monopolistic pricing.

Securing High Professional Standards

The Academy has attached hereto its policy on Credentialing Ambulatory Healthcare Facilities. The essentials of a standard setting procedure include adherence to medical guidelines from an impartial facility certifying organization, such as the Accreditation Association for Ambulatory Healthcare. The Academy believes a multi-disciplinary accreditation organization is superior to one that is controlled by a single specialty and that therefore is more susceptible to incestuous influences. Similarly, physicians should arrange for peer review of their facilities on a systematized basis (which is one of the criteria for accreditation by the Accreditation Association for Ambulatory Healthcare). Physicians operating ambulatory healthcare facilities should also receive continuing medical education, particularly in such new fields as laser surgery and liposuction, in which very few physicians received formal training in their initial residencies.

Securing Choices for Patient/Consumers Among Qualified Surgeons

Consumers also deserve free choices among qualified surgeons, unencumbered by doctor-monopolies. In the medical marketplace, as in the marketplace generally, consumers benefit by being able to cast their economic ballots among competing sellers. Healthy competition in the marketplace gives consumers choices that promote fair prices and a high quality of treatment. A consumer can "vote with his feet" if he has a choice. But, if the entrenched incumbent surgeon in a town has managed to keep out competition, the consumer has no choice; the patient/consumer must pay whatever price the monopoly-surgery demands and endure whatever service the monopoly-surgeon chooses to provide.

Several principles foster viable choices for the patient/consumer:

First, patient/consumer (and legislative decision-makers) should be suspicious of claims that only one surgical specialty can perform a procedure such as facial plastic surgery. In truth, the American Medical Association, the American Board of Medical Specialties and numberous other organizations unanimously state that surgeons from different specialties may possess equal competence in certain procedures. The modern board-certified otolaryngologist, for instance, likely received more training in surgery of the head and neck, including plastic and reconstructive surgery of that bodily region, than the general plastic surgeon, who necessarily devoted much of his training to abdominal surgery, hand surgery, foot surgery, etc. A physician claiming that his specialty desire a monopoly on competence is really saying that his specialty desires a monopoly on profits.

Second, accreditation of ambulatory healthcare facilities should be separated from the credentialing of physicians for hospital staff-privileges. Hospital staff-privilege decisions are notoriously petty and political. Often the decision to exclude a physician from a hospital staff is based on factors having nothing to do with the physician's competence. A hospital may, for instance, decide that it doesn't need another physician in a particular specialty, or that a physician's ambulatory healthcare facility competes with the hospital's own emergency room.

Often a new, young surgeon in a town may find his hospital privileges blocked by older incumbent surgeons with established practices who are afraid of the new competition. The incumbent surgeons further seek to restrict the new, young surgeon's ambulatory surgery by the excuse that the new surgeon doesn't have hospital surgical privileges for those procedures to be done in his ambulatory surgery unit. Again, "where you stand depends on where you sit," and decision-makers should be suspicious of entrenched specialists who urge the argument that accreditation of ambulatory healthcare facilities should be solely based on hospital staff privileges. (Accreditation of such ambulatory of such ambulatory facilities should, however, require that the facility have arrangements and procedures for instantaneous treatment of outpatient complications at a nearby hospital, and such arrangements are required by the Accreditation Association for Ambulatory Healthcare.) The Academy reaffirms its commitment to certification of surgical credentials through board certification and fellowship in the College of Surgeons.

Third, the market for healthcare services functions best in a deregulated environment. Governmental regulation carries the potential for substantial expenditure of tax dollars and increased prices for patient/consumers. It is the fondest dream of every monopolist that his legislature will outlaw future competition—particularly through some sort of standard-setting procedure. But government regulation of small businesses seldom benefits consumers or the majority of small businesses themselves. As the chairman of the FTC has pointed out, the unregulated free enterprise system doesn't have to work perfectly to work better than government regulation. There is no substantial evidence that government regulation would do any better in accrediting ambulatory healthcare facilities than organized medicine.

ASMC

April 21, 1989

D. Ann Murphy, Investigator
Subcommittee on Regulation & Business Opportunities
Committee on Small Business
B-363 Rayburn Building
Washington, D.C. 20515

Dear D. Ann:

I appreciate you seeing me on my recent visit to Washington. I always enjoy discussing my specialty, especially with someone as enthusiastic as you. Having worked with Doctor Singer in his office based surgical center for the past several years, I am quite aware of some of the potential pitfalls which may manifest themselves in this type of a practice of surgery.

My greatest concern, of course, is for the safety of the patient in the office based surgical setting. As an anesthesiologist, I have a very strong bias concerning the delivery of general anesthesia and/or conscious sedation. I believe that any alteration of consciousness with drugs may lead to an adverse outcome in a patient. I have referred to conscious sedation, which by definition is a state of altered consciousness without the complete loss of consciousness. This state is usually brought on by the administration of potent sedative drugs which are given intravenously. These drugs include narcotics, barbiturates, and tranquilizers. Administration of increased dosage of these drugs may lead to loss of consciousness. When consciousness is lost, the patient loses some of the protective reflexes which are present during consciousness, e.g. a patient may lose the ability to keep an open airway, may become apneic (stops breathing), loss of gag reflex (if patient vomits, the vomitus may pass into the lungs). There is a fine line between conscious sedation and unconsciousness with unconsciousness occurring, as mentioned before, with increased dosage. Also other important factors determining the proper dosage depends upon the age of the patient, the patient's weight, physical status of the patient, and psychological factors.

For these reasons I feel that optimum patient safety requires an individual other than the surgeon to be responsible for the administration of the sedative drugs, even though the standard of practice for many surgeons is to sedate their own patients personally.

As I mentioned during my visit, dentists and oral surgeons are coming to grips with these problems and are requiring trained individuals to participate in their surgical procedures. In other words, most dentists and oral surgeons are requiring a separate individual to administer the anesthesia. Many examples of tragic outcomes have been recorded due to over-sedation in the dental setting.

When referring to an individual educated in anesthesia, I refer to either an anesthesiologist or CRNA. Obviously, the doctor's receptionist is not such an individual.

We also discussed monitoring during my visit and I would like to explain which monitors we demand when practicing in an office setting. The blood pressure (BP) cuff may be a simple device with a hand-held dial mechanism or an automated device which shows the BP in flashing lights. The former device costs approximately $150 and the latter costs approximately $2500. An oscilloscopic ECG machine costs approximately $4,000. A defibrillator is approximately $3,000. An anesthetic machine, if one can be purchased in used condition, may range from several hundred dollars to $2,000. A new anesthetic machine, built specifically for office practice, can be purchased for around $3,000. The pulse oximeter costs approximately $2,000. More sophisticated anesthesia machines which are used in the hospital setting, for your information, will go as high as $55,000 to $65,000.

You also asked me to discuss the function of the above monitors. The BP machine will determine changes in the patient's BP, which may increase or decrease as the surgery progresses. An increased BP may signal a patient becoming anxious and more sedation will be required, whereas a falling BP may be due to over-sedation.

The ECG machine will show the patient's pulse rate and rhythm, and may also show patterns which signify decreased oxygen delivery to the heart. Medical knowledge is required for the interpretation of the information shown on the EKG.

The pulse oximeter is a monitoring device which is attached to a fingertip and shows the percentage of oxygen saturation in the artery being monitored. Interpretation of this information will inform the anesthesiologist of the adequacy of the patient's respirations.

The anesthesia machine may be used when the patient stops breathing, apnea, or for delivery of general anesthesia. Drugs required to administer a general anesthesia or drugs on the "crash cart" have not been described, but these can be purchased for approximately $500.

D. Ann, I am enclosing some additional information which may be informational to you. I hope this letter clarifies some of the information which I discussed during my visit and I stand ready to assist you in your endeavors to render safe patient care in the office surgical setting.

Sincerely,

Paul E. Thomas, M.D.
Paul E. Thomas, M.D.

PET:p
Enclosure

April 19, 1989

MEMO TO: CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS, INC.

RE: LEGISLATIVE UPDATE
AB 1417 (SPEIER) DENTAL CONSCIOUS SEDATION
SB 1211 (KEENE) PEER REVIEW

CSA - supported legislation moved forward yesterday on two fronts:

.... The Assembly Health Committee passed without opposition AB 1417 (Speier) to establish a permit system governing the use of conscious sedation in dental offices. CSA is working with the author and the California Dental Association on clarifying amendments regarding the role of physician-anesthesiologists in this context. A recent meeting of the CSA/CDA Liaison Committee has set the stage for a cooperative effort. AB 1417 still has a long way to go, but signs are hopeful that it will avoid the stalemate that has prevented passage of similar patient-safety bills in past years. The measure next moves to the Assembly Ways & Means Committee where it should be heard in the next few weeks.

.... The Senate Judiciary Committee passed SB 1211 (Keene), sponsored by the California Medical Association to insulate peer review activities from violation of state and federal anti-trust laws. A similar 1988 measure was the focus of a bitter fight between CMA and hospital organizations which resulted in a veto of the CMA-backed bill. A potential deadlock yesterday was broken by an amendment designed to clarify whether a federal statute, the Health Care Quality Improvement Act, is pre-emptive of state law. Essentially, the amendment says if federal law is clarified on this point, California will not "opt-out" of the federal program. The remaining thrust of SB 1211 is to strengthen the due process rights of physicians facing medical staff disciplinary proceedings. Even so, SB 1211 remains controversial and will be hotly debated by hospital forces when it next comes before the Senate Appropriations Committee.

WEB:vn

CALIFORNIA MEDICAL ASSOCIATION
COMMISSION ON LEGISLATION

APRIL 28, 1989

SPECIAL DISCUSSION CALENDAR

DENTISTRY -- CONSCIOUS SEDATION/GENERAL ANESTHESIA

AB 1417
BC
BURCH
SHABOT

(Speier) (as introduced) Dentistry: conscious sedation.

Existing law prohibits any dentist from administering or supervising the administration of general anesthesia, on an outpatient basis for dental patients, unless the dentist has a permit from the Board of Dental Examiners.

Existing law makes a statement of legislative findings and declarations relating to the use of conscious sedations.

The bill would prohibit, on and after January 1, 1992, any dentist from administering, ordering, or permitting the administration of, conscious sedation, on an outpatient basis, unless the dentist has a permit from the board.

The bill would specify the requirements necessary for the issuance o the permit, including educational requirements and the payment of a fee.

The bill would make it unprofessional conduct for (1) any dentist performing dental procedures to have more than one patient undergoin conscious sedation or general anesthesia at any given time unless ea patient is continuously monitored by the dentist or another health professional authorized to administer conscious sedation or anesthesia, (2) any dentist to fail to obtain the written consent of patient prior to administering conscious sedation, and (3) any dentis to fail to report, in writing, to the board within 7 days after the death or removal to a hospital or emergency center for medical treatment of any patient to whom conscious sedation or general anesthesia was administered.

Existing provisions of the Business and Professions Code continuousl appropriate the moneys in the State Dentistry Fund. (Sponsor: Author)

Pulse Oximeter in the Ambulatory Aesthetic Surgical Facility

Robert Singer, M.D., and Paul E. Thomas, M.D.
La Jolla, Calif.

One-hundred consecutive patients undergoing aesthetic surgical procedures with adjunctive intravenous sedation in an office-based ambulatory surgical facility were monitored by an anesthesiologist with an ECG, stethoscope, automatic sphygmomanometer, and pulse oximeter. The pulse oximeter detected hypoxemia occurring intraoperatively and in the recovery room earlier than the traditional methods of monitoring. By detecting early drops in the SAO_2 with the pulse oximeter, appropriate corrective measures could be instituted and titration of intravenous anesthetics adjusted, avoiding progression to more profound hypoxemia and thus resulting in the safer delivery of anesthesia. The pulse oximeter is a useful and recommended adjunct to the traditional methods of monitoring in an office-based ambulatory surgical facility.

The study was designed to evaluate use of the oxygen-saturation monitor (pulse oximeter) in patients undergoing aesthetic surgical procedures with adjunctive intravenous sedation in an office-based ambulatory surgical facility. The objective use of the pulse oximeter in this type of setting has not been previously reported in the plastic surgical literature.

Hypoxemia, insufficient oxygen in the blood, does not signify tissue hypoxia, but it should alert one to that possibility.[1] Intraoperative moderate to severe hypoxemia was reported in a series of patients undergoing aesthetic surgical procedures under intravenous sedation by Huang et al.[2] and by McNabb and Goldwyn,[3] while Vinnik,[4] Cunningham and McKinney,[5] and others have reported that no respiratory complications existed in their series.

This study incorporated the pulse oximeter to assess (1) if hypoxemia occurred in patients undergoing aesthetic procedures as outpatients in an office-based facility under intravenous sedation, (2) if there was a correlation between the traditionally monitored signs (blood pressure, ECG, respiratory rate, pulse rate, and clinical appearance) and the oxygen saturation values (SAO_2), and (3) whether the pulse oximeter was a useful tool in titrating levels of medication to prevent a progression of hypoxemia, if it existed.

MATERIALS AND METHODS

One-hundred consecutive patients undergoing a variety of aesthetic procedures, including facial (39 patients), nasal (27), and breast (34) operations, were evaluated. Patient ages ranged from 12 to 76 years. Each patient was monitored with the traditional ECG, automatic blood pressure device, precordial or pretrachial stethoscopes, and observation by a board-certified anesthesiologist. Additionally, a pulse oximeter was connected to the patient. Patients were monitored continuously throughout the operation and in the recovery room. The automatic blood pressure cuff was set to read blood pressure and pulse at 3-minute intervals, while the pulse oximeter updated the data with each heartbeat. All the patients were operated on by one author (Singer) and anesthetized by the other author (Thomas).

Anesthesia consisted of premedication with [illegible]0 mg Valium orally for adult patients or 25 mg Benadryl for children and teenagers. Patients were given intravenous sedation consisting of a combination of drugs administered by the anesthesiologist, including morphine, Demerol, Sublimaze, Inapsine, Valium, Versed, Vesprin, Brev-

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From the Section of Plastic and Reconstructive Surgery and the Department of Anesthesiology at the Scripps Memorial Hospital. Received for publication April 23, 1987; revised July 3, 1987.

Presented at the Annual Meeting of the American Society of Aesthetic Plastic Surgery, in Los Angeles, California, on March 23, 1987.

ital, or Benadryl, depending on the procedure and the patient's individual needs. Local anesthesia consisted of 2% Xylocaine with 1:100,000 epinephrine or, if larger volumes were used, 0.25% Xylocaine plus 1:400,000 epinephrine and 5% cocaine packs in nasal surgery. Patients were anesthetized to the level at which they became drowsy, cooperative, and free from anxiety and pain. That level varied with the patients as did the amount of medication necessary to achieve it.

Early in the study it became apparent that counting the respiratory rate, especially during the initial onset of anesthesia as well as while injecting local anesthetic, was not practical. If the SAO_2 began to drop precipitously, the patient was verbally stimulated regardless of his respiratory rate. If it continued to decrease, other techniques such as lifting the chin or insertion of a nasal or oral airway were employed. A Nellcor N-100 and an Ohmeda Biox 3700 pulse oximeter were used in this study. Changes in the blood pressure, pulse rate, and SAO_2 were statistically analyzed by the linear regression method. Hypoxemia was defined as the following:

No hypoxemia = SAO_2 95–100% = PAO_2 greater than 80 torr (mm's of mercury)

Mild = 89–94.5% = 60 to 80 torr

Moderate = 75–88.5% = 40 to 60 torr

Severe = less than 75% = less than 40 torr.

A reading of less than 40 torr represents the level at which the tissue's oxygenation capability is severely threatened.[1]

RESULTS

The pulse oximeter showed changes corresponding to the development of hypoxemia earlier than the traditional methods of monitoring. There was no correlation between the changes in SAO_2 and changes in the blood pressure, pulse rate, and ECG. The following graphs (Figs. 1 and 2) illustrate the random distribution of blood pressure and heart rate changes in relationship to SAO_2 values.

Blood pressure, pulse rate, and respiration were influenced by a variety of factors, including anxiety, pain with injection of local anesthetic, epinephrine uptake, discomfort, the effect of various intravenous medications, and bladder distention. Of these factors, only intravenous medication had an effect on the SAO_2. Thirty-nine percent (39%) of the patients exhibited no hypoxemia; 32%, mild (89–94.5% SAO_2); 28%, moderate (75–88.5% SAO_2); and 1%, severe (less than 75% SAO_2). This occurred even though the anesthesiologist was in constant attendance. However, hypoxemia was only transitory in nature, lasting 1 to 2 minutes in the majority of these patients. This usually occurred during the initial phase of anesthesia just before infiltration of local anesthetic. Upon seeing the decrease in SAO_2, the patients were verbally stimulated, resulting in their taking more frequent, deeper breaths, usually with a prompt return of the SAO_2 to normal limits. The amount of intravenous medication could then be titrated based on the SAO_2 to prevent a further drop, avoiding a progression of hypoxemia to a more profound level.

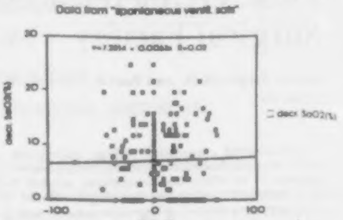

FIG. 1. A plot of the change in blood pressure in relationship to the decrease in SAO_2 in various patients during their procedures and in the recovery room. There was no correlation in the changes.

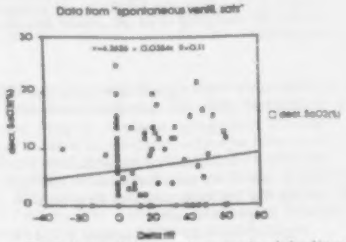

FIG. 2. A plot of changes in heart rate in relationship to decreases in SAO_2 in various patients during their procedures and in the recovery room. There was no correlation in the changes.

Mild hypoxemia lasting longer than 1 to 2 minutes occurred in 7 percent of patients; moderate, in 8 percent; and severe in 1 percent. An oral airway was inserted in two patients undergoing rhinoplasties, while a nasal airway was inserted in one patient undergoing a face lift, with prompt return of SAO_2 to normal limits in all these patients. Reversal of sedation with Narcan was not necessary in any patient, nor was supplementary oxygen, thus avoiding the concern of explosion or fire with the use of electrocautery.

The one patient who developed severe hypoxemia had a history of asthma. He underwent a rhinoplasty, septoplasty, and chin augmentation. In the middle of the procedure, the SAO_2 started to drop while vital signs and appearance were unchanged. Wheezing did not develop until the SAO_2 decreased to 60 percent. The pulse oximeter showed the onset of an asthmatic episode earlier than even auscultation. Intravenous administration of aminophylline resulted in a prompt return of the SAO_2 to normal limits.

Hypoxemia was seen more frequently during the infiltration of local anesthetic when maximum analgesia was desired, but it could occur at any time during the surgical procedure or in the recovery room. Its development was unpredictable based on the age of the patient (42.4 years arithmetic mean), length of the procedure, type of procedure, or amount of intravenous medication given.

DISCUSSION

The pulse oximeter is a noninvasive monitor that can be easily attached to the finger, ear, or toe. In most situations, the finger probe works best. Skin color and fingernail polish do not interfere with the monitor's accuracy. The correlation of SAO_2 as shown by pulse oximetry and arterial blood gases has been previously documented.[6,7]

FIG. 3. A pulse oximeter.

An oximeter measures the absorption of selected wavelengths of light passing through living tissue samples. Oxygenated hemoglobin and reduced hemoglobin have markedly different absorption characteristics at 600 nm of red light and 940 nm of infrared light. These two light sources are contained in the probe, which is applied to a digit. The pulsation of arterial blood flow present in a particular test site modulates the light the oximeter's probe detects. Since other fluids and tissues present at the test site generally do not pulse, they do not modulate the light passing through the test site area. By using the pulsatile portion of the incoming signal, a microprocessor receives the data, converting them to a display of pulse rate and SAO_2 in percentage form.[8]

The monitor may not be accurate in the following situations:

1. A restless patient may dislodge the probe. The Ohmeda pulse oximeter has a mode that will note low quality of signal if this occurs or if there is poor placement of the probe.
2. Radio-frequency current from electrocautery may disrupt the signal strength to the monitor during cautery.
3. Dyshemoglobin species that are present, e.g., methhemoglobin or carboxyhemoglobin, may give an erroneous reading.
4. Any event that significantly reduces vascular pulsation will reduce the instrument's ability to calculate saturation. These include severe peripheral vascular disease, hypothermia, a patient with a constricted peripheral vascular system due to an extremely cold room, a blood pressure cuff being inflated on the same arm as the pulse oximeter, hypotension with a systolic pressure of less than 50 mmHg, and infusion of vasoconstrictor drugs.

A pulse oximeter has a significant advantage over a transcutaneous monitor in that it does not require a warm-up period. Additionally, it does not heat the skin under the probe, which may result in thermal burns during long operations. Dynamically, it updates the SAO_2 with each heartbeat, compared to the intermittent readings of serial arterial blood gases. Watterson stated that "vigilance monitors should be able to detect the problem quickly and specifically so that corrective measures can be initiated before irreversible physiological harm can occur." Hemodynamic monitoring with invasive techniques is inappropriate as a primary vigilance monitor in outpatient settings.

Observation of the patient is a very imprecise method of determining hypoxemia. Cyanosis (the presence of 5 gm or more of reduced hemoglobin per 100 ml of blood) may not be overt until the SAO_2 falls to 65 percent. The perception of cyanosis is quite variable and a poor sign of early hypoxemia.

In 1981, Vinnik[4] presented a series of patients undergoing outpatient surgical procedures sedated with intravenous doses of Valium and ketamine. He stated that in all these patients respiration, blood pressure, pulse, and ECG were monitored. He concluded that "with careful observation of the patient and titration of the medication to clinical response, no respiratory or other problems had been observed." Cunningham and McKinney[5] reported no ventilatory complications in their 1983 series. In our present study, it was obvious that the traditional monitoring of respiration, blood pressure, pulse, and ECG was not effective in determining early hypoxemia. Measuring the SAO_2 with arterial blood gases or by the pulse oximeter, however, will show hypoxemia that would otherwise be undetected.

Presence of the monitor made the operating team and the anesthesiologist more aware of the possibility of hypoxemia, and its development was thereby avoided in many patients. If it did develop, the awareness of the decreased SAO_2 and the subsequent changes that were instituted helped prevent progression. In addition, the monitor was useful in determining whether the patient was anxious from oversedation or in fact from other factors, since oversedation with hypoxemia may cause anxiety.[10]

Hypoxemia also may extend into the recovery room. It is ideal to continue SAO_2 monitoring in that setting as well. When surgical stimulation ceases, the patient may become more sedated and hypoxemia may be seen. Patients are now routinely monitored with the pulse oximeter in the recovery room as well as in the room.

With use of the pulse oximeter and heightened awareness, the levels of hypoxemia seen in the series of Huang et al. (54 percent mild and 12 percent moderate in 24 patients undergoing rhytidectomy) and of McNabb and Goldwyn (mean PaO_2 of 74.2 mmHg in 20 patients undergoing face lifts or rhinoplasties) can be avoided, resulting in a safer delivery of intravenous sedation.

Robert Singer, M.D.
9834 Genesee Avenue, Suite 100
La Jolla, Calif. 92037

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Discussion

Pulse Oximeter in the Ambulatory Aesthetic Surgical Facility

by Robert Singer, M.D., and Paul E. Thomas, M.D.

Discussion by Bernard L. Kaye, M.D.

The pulse oximeter is a noninvasive, early warning, primary vigilance end-organ monitor whose availability was long overdue. Most systemic surgical problems start with hypoxemia, which is picked up immediately by the pulse oximeter. There is a significant delay (and exacerbation) of problems before they reflect themselves by changes in the ECG and blood pressure monitors.

Most of the pulse oximeters available at present incorporate a valuable auditory monitoring feature. Their auditory signals lower their pitch as oxygen saturation decreases, calling attention to decreasing SAO_2 values before they reach danger levels and set off lower-limit alarms.

I thoroughly agree with the authors' comment that observation of the patient is a very imprecise method of determining hypoxia. The day before drafting this discussion, I experienced a situation that strongly confirmed their observation. I was about to do a secondary procedure under general anesthesia on a patient who had undergone a noneventful primary operation 2 days previously. The anesthesiologist (the same physician who administered anesthesia previously) applied the pulse oximeter sensor prior to induction of anesthesia. He obtained a reading of 72 percent SAO_2. Because the patient showed no cyanosis, dyspnea, orthopnea, tachycardia, anxiety, or any other recognizable signs of hypoxia, he thought that he might have obtained a false reading due to a defect in the oximeter. He tested the pulse oximeter on his own finger, which showed an SAO_2 of 98 percent. Auscultation of the chest revealed moderate rales at both lung bases. Blood gases were then obtained showing a PO_2 of 43 and a metabolic alkylosis. A chest film was then obtained, which showed significant pulmonary congestion indicative of congestive failure. The operation was canceled, and the patient responded rapidly to medical treatment. This is an example of a potential disaster averted by the early warning capacity of the pulse oximeter.

Use of the pulse oximeter is particularly helpful for patients having procedures under local anesthesia with sedation because of the hypoventilation associated with administration of sedative agents. Unlike the authors, who use nasal or oral airways to improve ventilation, I use a no. 10 French nasal oxygen catheter inserted at least 3 inches into the nasopharynx (to prevent possible problems with the use of cautery) and secured to the upper lip with a Steri-Strip. The pulse oximeter shows that this can increase SAO_2 by 4 to 5 percent. It also tells me when to ask the patient to take a few deep breaths.

I agree with the authors that the use of the pulse oximeter in the recovery room is at least as important as its use in the operating room. Sedated patients are more likely to hypoventilate during recovery without the stimulation of surgery.

The pulse oximeter is rapidly being adapted as a primary vigilance monitor, and with good reason. We are indebted to Drs. Singer and Thomas for bringing the importance of this instrument to our attention.

Bernard L. Kaye, M.D.
Suite 702
Laurette Howard Doctor's Building
Jacksonville, Fla. 32207

Received for publication June 19, 1987.

APPLICATION FOR APPROVAL OF A NON-HOSPITAL FACILITY FOR THE PROVISION OF ANESTHESIA SERVICES BY ASMG, INC.

FACILITY :____

Address:____

____

____

Surgeon/Director of Facility:______________________________

REPRESENTATIONS AND WARRANTIES

To be eligible for anesthesia at non-hospital facilities, I represent and warrant the following:

1. The facility at which I request approval for non-hospital anesthesia meets all of the following conditions:
    - A. Resuscitation and suction equipment, including airways, endotracheal tubes, laryngoscope, O_2 supply sources with positive pressure capabilities (preferably an AMBU-type apparatus) are available at all times in both the operating room and recovery areas.
    - B. Appropriate crash carts, are present, checked and logged weekly, with sufficient supplies.
    - C. Appropriate drugs for CPR are available and consistent with current medical standards. At a minimum they include: sodium bicarbonate, calcium chloride, epinephrine, atropine, IV lidocaine, Inderal, Apresoline, Aminophyllin, Narcan, Dopamine, neosynephrine, ephedrine.
    - D. A defibrillator is available that is adaptable for battery and house current. It is checked and logged weekly.
    - E. Recovery area records are maintained documenting periodic and frequent recording of vital signs for post anesthesia patients. Recovery area records are a part of the patient's records.
    - F. Continuous recovery room care is provided by a trained Registered Nurse.
    - G. There is at least one dedicated operating room that is used exclusively for surgery and at least one separate post-anesthesia recovery room or other area designated for recovery.

H. Suitable surgical lighting is provided with an appropriate emergency lighting source available in the event of power failure.

I. The facility has a plan for transferring emergency cases requiring additional care to a (general) hospital approved by the Joint Commission on Accreditation of Hospitals.

J. The facility has plans for response to cardiac arrest and fire emergencies which are posted in prominent locations in the surgical suite and recovery area.

K. The surgeon and his operating personnel are trained in CPR and each possess a current CPR card.

L. A history and physical is a part of the record (a statement by the surgeon that a history and physical has been performed, summarizing the findings and the indication for surgery as scheduled may serve as a substitute).

M. A pre-anesthesia questionnaire is completed and signed by the patient.

N. Medical records are maintained by the facility include:

1. History and physical examination or substitute as outlined under L.
2. Operative report.
3. Progress notes.
4. Pre-operative medical record including medication administered, including dosage, time administered, route and response. All such records are prepared by the person administering such medication.
5. Surgical and anesthesia consent forms.
6. Documentation of laboratory work-up.
7. Anesthesia and recovery area records.
8. Pre-anesthesia and post-anesthesia notes.
9. Emergency phone numbers of the surgeon and anesthesiologist are included in every operative instructions to the patient. A duplicate of these instructions is maintained in the patient's record.

O. The patient will be discharged only to a responsible adult and will be accompanied by their post-operative instructions.

P. All surgeons performing procedures in a non-hospital facility will have identical privileges for that procedure in the nearest general hospital and they must document professional liability coverage of at least $500,000. Premise liability insurance coverage must be maintained by the facility.

Authorized Surgeon/Director: ______________________________

Date : ______________________________

2. **With respect to each patient for whom I provide their anesthesia in a non-hospital facility, I will:**

   A. **Verify that a history and physical exam or substitute as outlined under L. above and a laboratory report are included in the patient's chart prior to the administration of anesthesia.**
   B. **Enter my pre-anesthesia notes in the patient's record, accompanied by the patient's pre-anesthesia questionnaire.**
   C. **Use monitoring and anesthesia equipment consistent with accepted medical standards on every general anesthesia patient.**
   D. **Be present at all times during the administration of said anesthetic and to the completion of the surgical procedure.**
   E. **Write post-anesthesia orders for the recovery area personnel or verify that the surgeon has written such orders.**
   F. **Supervise the monitoring of post general anesthesia patients in the recovery area.**
   G. **Remain in the facility post-operatively until the patient has recovered adequately from the anesthetic. The decision to discharge the patient from the recovery area will be mine, but I may discharge the patient to the surgeon or another anesthesiologist. Before discharging the patient I will place the completed anesthesia records and post-anesthesia notes in the patient's chart.**

Authorized Anesthesiologist:______________________
(sign)

Date :______________________

If this application is approved, it will be kept on file with Anesthesia Service Medical Group, Inc. Authorization will be forwarded to you by the involved anesthesiologist.

Effective Date:______________________

Approved by ASMG Board of Directors______________________
President

____
Date

Howard A. Tobin, M.D., F.A.C.S.
Certified American Board of Cosmetic Surgery

FACIAL
PLASTIC
&
COSMETIC
SURGICAL
CENTER

6300 Humana Plaza
Abilene, Texas 79606
(915) 695-3630
(1-800-592-4533)

February 6, 1989

Frank Papineau
Rm. B363
House Rayburn Office Bldg.
Washington, D.C.

Dear Frank:

Since my last letter to you dated January 16, 1989, we have had the opportunity to talk on the phone and I indicated to you that I would write to you regarding my feelings on recertification and accreditation for outpatient surgical facilities.

Since its inception, The American Academy of Cosmetic surgery has been dedicated to the concept of high quality ambulatory surgical care. In point of fact, Dr. Richard Webster, the first president of the Society, established an Ambulatory Surgical Committee as the first such body to be formed. I had the privilege of being appointed as the first chairman.

Under Dr. Webster's leadership, and with the subsequent support of our next president, Dr. Julius Newman, The American Academy of Cosmetic Surgery formally applied to become a sponsoring member of the Accreditation Association for Ambulatory Healthcare. This organization (AAAHC) has taken a leadership role in the accreditation process for ambulatory surgical facilities of all types. Accreditation by AAAHC is a difficult but obtainable process which assures the surgeon that his private operating facility meets high standards in the areas of patient rights, administration, governance, medical records, quality of care, quality assurance, facilities and environment, operating and anesthesia services as well as a number of other areas.

I am aware that there are those who would state that an individual surgeon's credentials to carry out a specific operative procedure should be based upon whether or not he has those same credentials in a hospital. You and I are both aware of the fact that hospital credentials can be subject to political forces which may very well deny a qualified individual the right to carry out a procedure in which he has adequate experience and ability. AAAHC recognizes the importance of credentialling, but feels that the process should be based upon an individual's training, competence, ability and experience. This should be carried out independently by the surgical center in a manner that is subject to inspection by peer review. The American Academy of Cosmetic Surgery endorses this concept.

At our last annual meeting, the officers and directors of the Academy indicated to me that the Academy was planning to move in a direction that would more strongly encourage our members to seek accreditation. As I explained to you, our organization is primarily educational, and therefore cannot require accreditation. Nevertheless, I feel that we are in a position to significantly influence our members toward this process.

As an examiner for The American Board of Cosmetic Surgery, I have also had the opportunity to be involved in discussions regarding the concept of recertification. Dr. Richard Webster and I, over the past few days, had lengthy conversations about this topic and have communicated these views to Dr. Julius Newman who is a member of the Board. The following comments reflect my own understanding and feelings, and could not be construed as the official policy of the Board. Nevertheless, I think that you will find them representative.

The American Board of Cosmetic Surgery recognizes that not every individual who is certified by the Board has the same basic ability and experience. We also realize that practice patterns change and individuals develop competence in new procedures and may lose competence in those procedures which they do not regularly carry out. The Board also recognizes that when an individual is certified, the public deserves more assurance that the individual is currently competent in those procedures which he may be carrying out.

The Board is moving toward a direction in which candidates would originally be examined on a core of basic material which should be required of any surgeon who wishes to call himself a "Board Certified Cosmetic Surgeon". This material would include, but not necessarily be limited to, knowledge of advanced cardiac life support, knowledge of the basic procedures in cosmetic surgery and the indications for those operative procedures. In addition, basic knowledge in wound healing and other surgical principals would be required. Beyond that, candidates would be intensively examined on those procedures which they were regularly performing. When certified, they would be certified as cosmetic surgeons with demonstrated knowledge and experience in given areas. Subsequently, a process of recertification would be established whereby the certified individual would demonstrate continued experience and proficiency in those designated areas. If he wished to add new procedures, he would be required to demonstrate evidence of training, knowledge and experience. If he deleted procedures, then his certificate would no longer indicate demonstrated experience and proficiency in those areas.

Up until now, Board certification by the traditional Boards approved by The American Board of Medical Specialties have merely indicated that a candidate had accrued academic knowledge of a core curriculum offered during a residency program. Because of this, Board certification may have had little relevance to the surgeons actual practice patterns. Many surgeons currently use the mantel of "Board Certification" to indicate that they are proficient in procedures in which they may have had no actual training during a residency program years ago.

The American Board of Cosmetic Surgery may be the first Board to take steps toward providing the public with the information that it is actually seeking - namely whether or not an individual has current knowledge in a specific area of concern.

Those of us who have been active in The American Academy of Cosmetic Surgery and The American Board of Cosmetic Surgery are proud of the progress that we are making. In contradistinction to what others may assert, we feel that the field of cosmetic surgery is responding to a real need and real demand on the part of the American public. We are determined to continue to upgrade our specialty and take our just place among the other more established surgical specialties.

Sincerely,

Howard A. Tobin, M.D., F.A.C.S.

cc: Richard Caleel, D.O.
Julius Newman, M.D.
Richard Webster, M.D.
Thomas Alt, M.D.
Ron Moen, exec. dir. AAAHC

AAAHC SURVEY REPORT FORM

Name of Organization ____________________

Location ____________________

Dates of Survey ____________________

Surveyors: ____________________ Chairperson

____

____

____

____

Accreditation Association for Ambulatory Health Care, Inc.
9933 Lawler Avenue, Skokie, Illinois 60077-3702
(312) 676-9610

INSTRUCTIONS TO SURVEYORS

This survey report form is to be used in conjunction with the Accreditation Handbook for Ambulatory Health Care, 1987-88 edition. After evaluating the organization's compliance with the standards as stated in the Handbook, respond to each of the statements listed under the chapter headings.

Supporting comments must be written in the section to the right hand side of the statements for:

1. All responses checked under the headings "Partial Compliance," "Non-Compliance," and "Unsure."
2. All responses that require clarification or elaboration under the heading "Substantial Compliance."

- Also provide supporting and summary comments for each chapter stating what documents, interview comments, observations, or other factors contributed to the decision regarding compliance or non-compliance.

- There is space provided within each chapter for consultative comments made to the organization that are not directly related to the standards.

- There is space provided within each chapter for recommendations made to the organization regarding the standards.

- There is space provided at the end of the survey report form for any special comments to the Accreditation Committee, which will aid the Committee in rendering the accreditation decision.

- A chart is provided at the end of the survey report form for recommending an accreditation decision to the Accreditation Committee for each chapter, as well as the survey team's overall recommendation regarding accreditation, deferral, or non-accreditation.

SC — **Substantial Compliance** indicates that the organization's current operations are acceptable and meet the standards.

PC — **Partial Compliance** indicates that a portion of the item is acceptable, but other areas need to be addressed.

NC — **Non-Compliance** indicates that the organization's operations in the area do not meet the standards.

UNS— **Unsure** indicates that the assessment team was unable to determine an appropriate response.

N/A— **Not Applicable** indicates that the standard does not apply to the organization.

Staff review of the presurvey materials, supporting documents and (if applicable) previous survey reports indicates that the following areas need special attention by the survey team:

1)	Pg. 3, #2	Review information regarding patient satisfaction to determine disposition of any problems.
2)	Pg. 5, #10	Review advertising and marketing materials to determine if they reflect capability of organization and credentials and training of staff.
3)	Pg. 5, #11	Review minimum components of risk management program, Standard 2B-15.
4)	Pg. 9, #20 & Pg. 34, #104	Spot-check licensure and credentials of physician and non-physician health care providers.
5)	Pg. 13, #60	Although diagnostic summaries are generally not required in surgical centers, determine if appropriate information is contained elsewhere in the medical record.
6)	Pg. 14, #41	Verify documentation of drug sensitivities on patients' medical records.
7)	Pg. 24, #91	Determine if drugs and pharmaceutical supplies utilized in-house are in compliance with standards.
8)	Pg. 31, #96	Are authenticated reports provided by outside radiologists?
9)	Pg. 36, #111	Who make decision regarding research? Review charts of patients involved in research to determine if protocols are followed. Are research entries clearly contrasted with entries regarding provision of care?

The survey team responses to the staff comments on page two are itemized below:

1) There is a process for reviewing patient satisfaction. Problems identified are disposed of in a satisfactory fashion.

2) At the present time this facility does no active marketing.

3) This facility provides the necessary components of a risk management program. At the present time there is no litigation pending. Incident reports are reviewed and made a part of the quality assurance program. Adverse reactions are addressed by the Peer Review Committee. Patient complaints are resolved in relation to the patient satisfaction questionnaire.

4) The licensure was current.

5) Diagnostic summaries are not necessary for the surgical record. The office clinical record does contain information relating to the patient's past history; however, the space for this is not easily updatable.

6) Most charts contain documentation of drug sensitivities. One medical record was lacking this.

7) Drugs and pharmaceuticals are in compliance with the standards.

8) Authenticated reports are provided.

9) No active clinical research takes place at the facility.

The survey team responses concerning recommendations made at the time of the previous survey (if applicable) are itemized below:

Was the information provided by the organization in the presurvey materials consistent with the surveyors' observations?

Yes X   No   Unsure

If no, or unsure, indicate what was found:

Was the Notice of Accreditation Survey posted in a public place in all facilities four weeks prior to the survey?

Yes X   No   Unsure

If no, or unsure, indicate what was found:

NOTE: If the notices have not been posted, please notify AAAHC staff immediately after the survey.

If the organization has more than one facility, were they all inspected?

Yes   No   Not Applicable X

If no, please explain why not.

Please provide a brief description of any additional service locations. Include information on the quality of care rendered, medical records, and facilities and environment. If applicable, also include information on pharmaceutical services, pathology and medical laboratory services, radiology services, and surgical services. (If more space is needed, please continue on page 7.)

1. Rights of Patients

AN ACCREDITABLE ORGANIZATION RECOGNIZES THE BASIC HUMAN RIGHTS OF PATIENTS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.		COMPLIANCE				
		SC	PC	NC	UNS	N/A
A. Patients are treated with respect, consideration, and dignity.	A.	X				
B. Patients are provided appropriate privacy.	B.	X				
C. Patient disclosures and records are treated confidentially, and, except when required by law, patients are given the opportunity to approve or refuse their release.	C.	X				
D. Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.	D.	X				
E. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.	E.	X				
F. Information is available to patients and staff concerning: patient rights, including those specified in A,B,C,D, and E above; patient conduct and responsibilities; services available at the organization; provisions for after-hours and emergency coverage; fees for services; payment policies; the right to refuse to participate in experimental research; and methods for expressing grievances and suggestions to the organization.	F.	X				
G. Patients are informed of their right to change primary or specialty physicians if other qualified physicians are available.	G.	X				
H. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.	H.	X				

1. **Rights of Patients**

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

2. Governance

AN ACCREDITABLE ORGANIZATION HAS A GOVERNING BODY THAT SETS POLICY AND IS RESPONSIBLE FOR THE ORGANIZATION. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
A. The organization is a legally constituted entity in the state(s) in which it is located and provides services. The organization is constituted by at least one of the following: charter, articles of incorporation, partnership agreement, franchise agreement, or legislative or executive act.	A.	X				
B. The governing body addresses and is fully responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to,	B.	X				
1. determining the mission, goals, and objectives of the organization	1.	X				
2. assuring that the facilities and personnel are adequate and appropriate to carry out the mission	2.	X				
3. establishing an organizational structure and specifying functional relationships among the various components of the organization	3.	X				
4. adopting bylaws or similar rules and regulations for the orderly development and management of the organization	4.	X				
5. adopting policies or procedures necessary for the orderly conduct of the organization	5.	X				
6. assuring that the quality of care is evaluated and that identified problems are appropriately addressed	6.	X				
7. reviewing all legal and ethical matters concerning the organization and its staff, and when necessary, responding appropriately	7.	X				
8. maintaining effective communication throughout the organization	8.	X				
9. establishing a system of financial management and accountability appropriate to the the organization	9.	X				
10. determining a policy on the rights of patients	10.	X				
11. approving all major contracts or arrangements affecting the medical care provided under its auspices, including, but not limited to, those concerning	11.	X				
a. the employment of practitioners	a.	X				
b. the provision of diagnostic imaging services and pathology and medical laboratory service	b.	X				
c. the use of external laboratories	c.	X				

2. Governance

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

2. Governance (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
d. the provision of care by other health care organizations, such as hospitals	d.	X				
e. the provision of education to students and postgraduate trainees	e.	X				
12. formulating long-range plans in accordance with the mission, goals, and objectives of the organization	12.	X				
13. operating the organization without limitation because of race, creed, sex, or national origin	13.	X				
14. assuring that all marketing and advertising concerning the organization do not imply that it provides care or services that it is not capable of providing	14.	X				
15. developing a policy on risk management appropriate to the organization including, but not limited to,	15.	X				
a. periodic review of all litigation involving the organization and its staff and health care practitioners	a.	X				
b. periodic review of all incidents reported by staff and patients	b.	X				
c. review of all deaths, trauma, or adverse reactions occurring on premises	c.	X				
d. resolution of patient complaints	d.	X				
16. determining a policy on continued education for personnel	16.	X				
C. The governing body provides for full disclosure of ownership.	C.	X				
1. The name and addresses of all owners or controlling parties (whether individuals, partnerships, trusts, corporate bodies, or subdivision of other bodies, such as public agencies or religious, fraternal, or other philanthropic organizations) are furnished to the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).	1.	X				
2. For corporations, the names and addresses of all officers, directors, and principal stockholders, either beneficial or of record, are available to the public upon request and are furnished to the AAAHC.	2.	X				

2. Governance (Cont'd.)

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

A more formal approach to risk management could be taken as part of a quality assurance meeting. At each quality assurance meeting, the following questions are asked:

1. Are there any incident reports from this term?
2. Is there any legal action pending?
3. Are there any risks to patients that have been identified in the past term?

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

2. Governance (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
3. Accredited organizations must notify AAAHC within 30 days of any significant change in ownership (such as a merger, change in majority interest, consolidation), name change, scope of services, or additional services or locations.	3.	X				
D. The governing body meets at least annually and keeps such minutes or other records as may be necessary for the orderly conduct of the organization.	D.	X				
E. If the governing body elects, appoints, or employs officers and administrators to carry out its directives, the authority, responsibility, and functions of all such positions are defined.	E.	X				
F. When a majority of its members are physicians, the governing body, either directly or by delegation, makes initial appointments, reappointments, and assignment or curtailment of medical privileges. When a majority of the members of the governing body are not physicians, the organization's bylaws or similar rules and regulations specify a procedure for establishing medical review for the purpose of making initial appointments, reappointments, and assignment or curtailment of medical privileges.	F.	X				
G. The governing body provides for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for non-physician health care personnel and practitioners.	G.	X				

2. Governance (Cont'd.)

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

3. Administration

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
AN ACCREDITABLE ORGANIZATION IS ADMINISTERED IN A MANNER THAT ASSURES THE PROVISION OF HIGH-QUALITY HEALTH SERVICES AND THAT FULFILLS THE ORGANIZATION'S MISSION, GOALS, AND OBJECTIVES. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.						
A. Administrative policies, procedures, and controls are established and implemented to assure the orderly and efficient management of the organization. Administrative responsibilities include, but are not limited to,	A.	X				
1. enforcing policies delegated by the governing body	1.	X				
2. employing qualified management personnel	2.	X				
3. long-range and short-range planning for the needs of the organization, as determined by the governing body	3.	X				
4. taking all reasonable steps to comply with applicable laws and regulations	4.	X				
5. protecting the assets of the organization	5.	X				
6. implementing fiscal controls including, but not limited to,	6.	X				
a. authorization and record procedures that are adequate to provide accounting controls over assets, liabilities, revenues, and expenses	a.	X				
b. policies and procedures for controlling accounts receivable and accounts payable and for handling cash and credit arrangements	b.	X				
c. rates and charges for services provided by the organization	c.	X				
7. using methods of communicating and reporting designed to assure the orderly flow of information within the organization	7.	X				
8. controlling the purchase, maintenance, and distribution of the equipment, materials, and facilities of the organization	8.	X				
9. establishing lines of authority, accountability, and supervision of personnel	9.	X				
10. establishing controls relating to the custody of the official documents of the organization	10.	X				
11. maintaining the confidentiality, security, and physical safety of data on patients and staff.	11.	X				
B. Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization.	B.	X				

3. Administration

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

3. Administration (cont'd)

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
Personnel policies						
1. define and delineate functional responsibilities and authority	1.	X				
2. require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification	2.	X				
3. require periodic appraisal of each person's job performance	3.	X				
4. describe incentives and rewards	4.	X				
5. require periodic review of employee compensation	5.	X				
6. specify responsibilities and privileges of employment	6.	X				
7. are made known to employees at the time of employment	7.	X				
C. The organization periodically assesses patient satisfaction with services and facilities provided by the organization. The findings are reviewed by the governing body, and when appropriate, corrective actions have been taken.	C.	X				
D. When students and postgraduate trainees are present, their status is defined in the organization's personnel policies.	D.	X				

3. Administration (Cont'd.)

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

4. Quality of Care Provided

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
AN ACCREDITABLE ORGANIZATION PROVIDES HIGH-QUALITY HEALTH CARE SERVICES IN ACCORDANCE WITH THE PRINCIPLES OF PROFESSIONAL PRACTICE AND ETHICAL CONDUCT, AND WITH CONCERN FOR THE COSTS OF CARE. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.						
A. All health care practitioners have the necessary and appropriate training and skills to deliver the services provided by the organization.	A.	X				
B. Health care practitioners practice their professions in an ethical and legal manner.	B.	X				
C. All personnel assisting in the provision of health care services are appropriately trained, qualified, and supervised and are available in sufficient numbers for the care provided.	C.	X				
D. The provision of high-quality health care services is demonstrated by at least the following:	D.		X			
1. education of, and effective communication with, those served concerning the diagnosis and treatment of their medical conditions, appropriate preventive measures, and use of the health care system	1.	X				
2. accessible and available health services	2.	X				
3. appropriate and timely diagnosis based on findings of the initial assessment (history and physical examination)	3.	X				
4. treatment that is consistent with clinical impression or working diagnosis	4.	X				
5. appropriate and timely consultation	5.	X				
6. absence of clinically unnecessary diagnostic or therapeutic procedures	6.		X			
7. appropriate and timely referrals	7.	X				
8. appropriate and timely follow up of findings and tests	8.	X				
9. patient cooperation	9.	X				
10. continuity of care	10.	X				
11. provision for services when the organization's facilities are not open	11.	X				
12. appropriate, accurate, and complete medical record entries	12.		X			
13. adequate transfer of information when patients are transferred to and from other health care providers	13.	X				
14. patient satisfaction	14.	X				
E. When clinically indicated, patients are contacted as quickly as possible for follow up regarding significant problems and/or abnormal laboratory or radiologic findings that have been identified.	E.	X				

4. Quality of Care Provided

1. INDICATE HOW MANY PATIENT RECORDS WERE REVIEWED: 16

2. DESCRIBE HOW THE PATIENT RECORDS WERE SELECTED: Random. We reviewed 16 medical records indepth.

SUPPORTING AND SUMMARY COMMENTS:

D. There were several cases in which the clinical medical record did not adequately support the conclusion that surgery was indicated. The indications for such procedures were not clear from the record.

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

The clinical medical record should clearly reflect the reasons for surgical procedures.

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

The provision of high-quality health care services should be demonstrated by the absence of clinically unnecessary diagnostic or therapeutic procedures; and appropriate, accurate, and complete medical record entries.

4. Quality of Care Provided (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
F. When the need arises, patients are transferred from the care of one health care practitioner to another.	F.	X				
1. Adequate specialty consultation services are available by prior arrangement.	1.	X				
2. Referral to a health care practitioner is clearly outlined to the patient and arranged with the accepting health care practitioner prior to transfer.	2.	X				
G. Concern for the costs of care is demonstrated by the following:	G.		X			
1. the relevance of health care services to the needs of the patients	1.		X			
2. the absence of duplicative diagnostic procedures	2.	X				
3. the appropriateness of treatment frequency	3.	X				
4. the use of the least expensive alternate resources when suitable	4.		X			
5. the use of ancillary services that are consistent with patients' needs	5.	X				
H. When the need arises, provisions are made for health care practitioners and other staff to communicate with patients in the language primarily used by them.	H.	X				

4. Quality of Care Provided (Cont'd)

SUPPORTING AND SUMMARY COMMENTS:

G. There is a lack of evidence that cost-of-care is a concern. In several cases the medical record does not substantiate a need for the more expensive form of treatment that was utilized.

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

It is suggested that cost-of-care issues be addressed by the Quality Assurance Committee. For example, a quality assurance study could be to review the medical record, both surgical and clinical, of every patient whose preoperative visual acuity was 20/40 or better. The study would be aimed at determining whether the benefit to the patient was worth the expense to the patient or the patient's insurance company.

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

Concern for the costs of care should include the relevance of health care services to the needs of the patients; and the use of the least expensive alternate resources when suitable.

5. Quality Assurance Program

	COMPLIANCE				
	SC	PC	NC	UNS	N/A
IN STRIVING TO IMPROVE THE QUALITY OF CARE AND TO PROMOTE MORE EFFECTIVE AND EFFICIENT UTILIZATION OF FACILITIES AND SERVICES, AN ACCREDITABLE ORGANIZATION MAINTAINS AN ACTIVE, ORGANIZED, PEER-BASED, QUALITY ASSURANCE PROGRAM AS AN INTEGRAL PART OF PROFESSIONAL AND ADMINISTRATIVE PRACTICE. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.					
A. The professional and administrative staff understands, supports, and participates in the quality assurance program through an organized mechanism responsible to the governing body.		X			
B. At least two physicians are involved in quality assurance activities in order to provide peer-based review. (In solo physician organizations, such as office-based surgical practices and independent practice associations, an outside physician is involved in quality assurance activities to provide peer-based review.)	X				
C. The quality assurance program addresses clinical, administrative, and cost-of-care issues, as well as actual or potential problems affecting patient outcomes (results of care). Exclusive concentration on administrative or cost-of-care issues does not fulfill this requirement.		X			
D. Quality assurance activities conducted by specific clinical disciplines within the organization (individual medical specialties, nursing, and so forth) are consistent with the characteristics of the organization's overall quality assurance program.					X
E. The organization provides ongoing monitoring of important aspects of the care provided.	X				
F. Health care practitioners participate in the development and application of the criteria used to evaluate the care they provide.		X			
G. Data related to established criteria are collected on an ongoing manner.					X
H. Collected data are periodically evaluated to identify unacceptable or unexpected trends or occurrences that influence patient outcomes (results of care).			X		

5. Quality Assurance Program

SUPPORTING AND SUMMARY COMMENTS:

A. The medical staff supports quality assurance activities but does not have a good understanding of the need for quantification and restudy.

C. The quality assurance program relies on the incident report to generate a study. This leads to rather superficial studies in this case. Cost-of-care issues are not addressed.

F. The health care practitioners have not established criteria to evaluate the care they provide.

H. Collected data has not been periodically reviewed. The problem is two-fold. One, the quality assurance program is in its infancy and, two, the idea of quality assurance studies has not been comprehended by the medical staff.

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

Efforts should be continued to ensure that the professional staff understands the quality assurance program which should address clinical, administrative, and cost-of-care issues, as well as actual or potential problems affecting patient outcomes. Health care practitioners should participate in the development and application of the criteria used to evaluate the care they provide. Collected data should be periodically evaluated to identify unacceptable or unexpected trends or occurrences that influence patient outcomes.

5. Quality Assurance Program (cont'd)

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
I. Quality assurance activities have the following characteristics:	I.	X				
1. Important problems or concerns in the care of patients are identified. Sources of identifiable problems include, but are not limited to, a. unacceptable or unexpected results of ongoing monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal test results, radiology film retakes, prescribing errors for medications, specific diagnoses, and so forth b. the clinical performance and practice patterns of health care practitioners c. medical record review for quality of care and completeness of entries d. quality controls for and use of diagnostic imaging, pathology, medical laboratory services, and pharmacy e. other professional and technical services provided f. assessment of patient satisfaction g. direct observation h. staff concerns i. accessibility j. medical/legal issues k. wasteful practices	1.		X			
2. The frequency, severity, and source of suspected problems or concerns are evaluated. Health care practitioners participate in the evaluation of the problems or concerns identified	2.	X				
3. Measures are implemented to resolve important problems or concerns that have been identified. Health care practitioners as well as administrative staff participate in the resolution of the problems or concerns that are identified.	3.	X				
4. The problems or concerns are re-evaluated to determine objectively whether the corrective measures have achieved and sustained the desired result. If the problem remains, alternate corrective actions are taken as needed to resolve the problem.	4.		X			
5. Through the organization's designed mechanisms, quality assurance activities are reported, as appropriate, to the proper personnel, the chief executive officer, and the governing body.	5.	X				

5. Quality Assurance Program (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

1. Unexpected results of surgery (leaks in more than ten patients) was not identified as a problem and was not discussed or studied as a quality assurance activity. The charts of these patients were reviewed by the Peer Review Committee but the issue was carried no further other than determining that each case was handled properly individually.

   Quality assurance studies in some cases have been reevaluated but not in a satisfactory quantitative way.

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

The quality assurance program is documented in the minutes but not in an easily manageable fashion. It is suggested that a separate quality assurance book be established and that minutes of the meeting be included with suggestions for quality assurance studies. The actual studies could then follow in relation to that meeting.

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

Important problems or concerns in the care of patients should be identified and reevaluated to determine objectively whether the corrective measures have achieved and sustained the desired result.

5. Quality Assurance Program (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
J. To permit flexibility and encourage innovation and variation, no particular method of conducting quality assurance activities is specified or required for accreditation. However, exclusive concentration on ongoing monitoring of care, without evidence of resolving problems, does not fulfill this standard.	J.		X			
K. Findings of quality assurance activities are incorporated into the organization's educational activities.	K.	X				
L. Appropriate records of quality assurance activities are maintained.	L.	X				

When were the first quality assurance studies begun by the organization? 86

How many studies have been conducted in the three years prior to the survey? 3 this yr. 2 last yr. 2 prev. yr.

How many studies were reviewed by the survey team? All.

5. Quality Assurance Program (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

J. The quality assurance studies are generated heavily by incident reports. Multiple methods of quality assurance activity identification are not utilized.

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

The organization is encouraged to be innovative in utilizing multiple methods of conducting quality assurance activities.

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

6. Medical Records

		COMPLIANCE				
AN ACCREDITABLE ORGANIZATION MAINTAINS A MEDICAL RECORD SYSTEM FROM WHICH INFORMATION CAN BE RETRIEVED PROMPTLY. MEDICAL RECORDS ARE LEGIBLE, DOCUMENTED ACCURATELY IN A TIMELY MANNER, AND READILY ACCESSIBLE TO HEALTH CARE PRACTITIONERS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.		SC	PC	NC	UNS	N/A
A. The organization develops and maintains a system for the collection, processing, maintenance, storage, retrieval, and distribution of patient medical records.	A.	X				
B. An individual medical record is established for each person receiving care.	B.	X				
C. All clinical information relevant to a patient is readily available to authorized health care practitioners anytime the organization is open to patients.	C.	X				
D. Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.	D.	X				
E. There is a person designated in charge of medical records whose responsibilities include, but are not limited to,	E.	X				
1. the confidentiality, security, and physical safety of medical records	1.	X				
2. the timely retrieval of individual medical records upon request	2.	X				
3. the unique identification of each patient's medical record	3.	X				
4. the supervision of the collection, processing, maintenance, storage, retrieval, and distribution of medical records	4.	X				
5. the maintenance of a predetermined organized medical record format	5.	X				
F. Policies concerning medical records address, but are not limited to,	F.	X				
1. the retention of active records	1.	X				
2. the retirement of inactive medical records	2.	X				
3. the timely entry of data in medical records	3.	X				
4. the release of information contained in medical records	4.	X				

6. Medical Records

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

6. Medical Records (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
G. Except when otherwise required by law, the content and format of medical records, including the sequence of information, are uniform.	G.	X				
H. Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operating reports, and consultations) are reviewed and incorporated into the medical record in a timely manner.	H.	X				
Ii. If a patient's medical record is complex and lengthy, a summary of significant past surgical procedures as well as past and current diagnoses or problems is conspicuously documented in the patient's medical record to facilitate the ongoing provision of rational medical care. The summary is legibly recorded in the same location in all patient charts. The summary does not repeat problems or diagnoses that recur during ongoing treatment. The summary includes, but is not limited to,	Ii.					X
1. significant surgical conditions, including major procedures	1.					X
2. significant medical conditions, including medical diagnoses of conditions for which the patient receives medication or treatment on a repeated or continuing basis	2.					X
3. conditions that are likely to significantly influence future care	3.					X
Iii If a patient's record is not complex and lengthy, the record should contain appropriate and adequate information to facilitate the ongoing provision of relational medical care	Iii	X				
a. How long have diagnostic summaries been used? Not applicable.						
b. How many records were reviewed? 16						
c. How many diagnostic summaries were reviewed? Not applicable.						
d. How many diagnostic summaries were missing significant diagnoses? ________						

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6. Medical Records (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

The surgical medical record does not require a diagnostic summary. However, it is recommended that the office medical record institute a diagnostic summary. This should be located in a consistent place in each chart and be updatable. It should contain information related to the general health of the patient including major past surgical procedures and it should contain all significant medical history such as diabetes or hypertension.

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

6. Medical Records (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
J. The presence or absence of allergies and untoward reactions to drugs is recorded in a prominent and uniform location in all patient charts on a current basis.	J.	x				
K. Entries in a patient's medical record for each visit include, but are not limited to,	K.	x				
1. date, department (if departmentalized), and provider name and profession	1.	x				
2. chief complaint or purpose of visit	2.	x				
3. clinical findings	3.	x				
4. diagnosis or medical impression	4.	x				
5. studies ordered, such as laboratory or x-ray studies	5.	x				
6. therapies administered	6.	x				
7. disposition, recommendations, and instructions given to the patient	7.	x				
8. signature or initials of practitioner	8.	x				
L. Significant medical advice given to a patient by telephone is entered in the patient's medical record and appropriately signed or initialed.	L.	x				
M. Entries in patients' medical records are legible to the clinical personnel in the organization.	M.	x				

a. If partial compliance, non-compliance or unsure, specify the number of records not legible to members of the surveyed organization and how this was determined.

b. Does the illegibility appear to be restricted to a specific department or practitioner?

6. Medical Records (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

6. Medical Records (cont'd)

	SC	PC	NC	UNS	N/A
N. Any notation in a patient's medical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.					X
O. When necessary for assuring continuity of care, summaries of records of a patient who was treated elsewhere (such as by another physician, hospital, ambulatory surgical service, nursing home, or consultant) are obtained.	X				
P. When necessary for assuring continuity of care, summaries of the patient's record are transferred to the health care practitioner to whom the patient was referred and, if appropriate, to the organization where future care will be rendered.	X				

6. Medical Records (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

7. Professional Improvement

	COMPLIANCE				
	SC	PC	NC	UNS	N/A
AN ACCREDITABLE ORGANIZATION STRIVES TO IMPROVE THE PROFESSIONAL COMPETENCE AND SKILL, AS WELL AS THE QUALITY OF PERFORMANCE, OF THE HEALTH CARE PRACTITIONERS AND OTHER PROFESSIONAL PERSONNEL IT EMPLOYS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.					
A. The organization provides for convenient access to library services that include materials pertinent to the clinical, educational, administrative, and research services offered by the organization.	A. X				
B. The organization provides adequate orientation and training to familiarize all personnel with the organization's policies, procedures, and facilities.	B. X				
C. The organization encourages participation in seminars, workshops, and other educational activities pertinent to its mission, goals, and objectives.	C. X				
D. When attendance at educational activities is required of professional personnel, the organization accepts evidence of participation in relevant external educational programs.	D. X				
E. The organization provides a monitoring function to assure the continued maintenance of licensure and/or certification of professional personnel.	E. X				

7. **Professional Improvement**

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

8. Facilities and Environment

	COMPLIANCE				
AN ACCREDITABLE ORGANIZATION PROVIDES A FUNCTIONALLY SAFE AND SANITARY ENVIRONMENT FOR ITS PATIENTS, PERSONNEL, AND VISITORS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.	SC	PC	NC	UNS	N/A
A. The organization assures that its facilities	A. X				
1. comply with applicable federal, state, and local building codes and regulations	1. X				
2. comply with applicable federal, state, and local fire prevention regulations	2. X				
3. are inspected at least annually by the local or state fire control agency, if this service is available in the community	3. X				
4. contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type	4. X				
5. have prominently displayed illuminated signs with emergency power capability at all exits from each floor or hall	5. X				
6. have alternate lighting, as appropriate to the facility, to provide adequate evacuation of patients and staff in case of an emergency	6. X				
7. have stairwells protected by fire doors	7. X				
B. The organization has the necessary personnel, equipment, and procedures to handle medical emergencies that may arise in connection with services sought or provided. At a minimum the organization provides	B. X				
1. periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment	1. X				
2. a comprehensive emergency plan to address internal and external emergencies, including	2. X				
a. a provision for the safe evacuation of patients during an internal emergency, especially patients who have difficulty walking	a. X				
b. a provision for the most efficient use of available facilities and services during an external emergency	b. X				
c. a requirement for at least four drills a year of the internal emergency plan	c. X				
3. personnel trained in cardiopulmonary resuscitation and the use of cardiac emergency equipment present in the facility during hours of operation	3. X				

8. **Facilities and Environment**

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

8. Facilities and Environment (cont'd)

		COMPLIANCE				
		SC	PC	NC	UWS	N/A
C. Smoking is prohibited in such areas as operating rooms, anesthetizing locations, rooms where oxygen and other volatile gases are administered or stored, and other hazardous areas. Smoking is permitted only in designated areas.	C.	x				
D. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are eliminated.	D.	x				
E. Reception areas, toilets, and telephones are provided in accordance with patient and visitor volume.	E.	x				
F. When appropriate, adequately marked patient and visitor parking is provided.	F.	x				
G. Provisions are made to reasonably accommodate handicapped individuals.	G.	x				
H. All examination rooms, dressing rooms, and reception areas are constructed and maintained in a manner that assures patient privacy during interviews, examinations, treatment, and consultation.	H.	x				
I. Adequate lighting and ventilation are provided in all areas.	I.	x				
J. Facilities are clean and properly maintained.	J.	x				
K. Food, snack services, and refreshments provided to patients meet their clinical needs and are prepared, stored, served, and disposed of in compliance with local health department requirements.	K.	x				
L. Procedures should be available to minimize sources and transmission of infection, including adequate surveillance techniques.	L.	x				
M. A system exists for the proper identification, management, handling, transport, treatment, and disposition of hazardous materials and wastes whether solid, liquid, or gas.	M.	x				
1. This system includes, but is not limited to, infectious, radioactive, chemical, and physical hazards.	1.	x				
2. The system provides for the protection of patients, staff, and the environment.	2.	x				

8. Facilities and Environment (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING E STANDARDS:

8. Facilities and Environment (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
N. The space allocated for a particular function or service is adequate for the activities performed therein, including space allocated for pathology and medical laboratory services, diagnostic imaging services, pharmaceutical services, examination and treatment rooms, offices, operating rooms, recovery areas, storage rooms, reception areas, medical records and other special function areas.	N.	X				
O. Appropriate emergency equipment and supplies are maintained and readily accessible to all areas of each patient care service site.	O.	X				
P. Equipment is properly maintained and periodically tested.	P.		X			
Q. Alternate power adequate for the protection of the life and safety of patients and staff is available. Special attention is given to	Q.			X		
1. operative and recovery areas for surgical services	1.			X		
2. treatment areas where emergency services are provided	2.					X
R. New facilities constructed by accreditable organizations comply with Section 12-6 "New Ambulatory Health Care Centers," Chapter 26, and other sections as may be applicable, of the 1981 edition of the Life Safety Code®, (NFPA 101®) published by the National Fire Protection Association, Inc., unless otherwise provided for by state law, local code, or appropriate jurisdiction having authority.**	R.	X				

**Life Safety Code® and 101® are registered trademarks of the National Fire Protection Association, Quincy, Massachusetts. Although revisions have been made, the 1981 edition is the only edition applicable for accreditation purposes.

8. Facilities and Environment (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

P,Q. The back-up power supply for the operating room has not been periodically tested. There has been no maintenance performed on this unit for two years. Upon testing this unit it was found to be not working. This system would not have operated in the event of an emergency. This organization has probably not had back-up power for the past six months.

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

Equipment should be properly maintained and periodically tested.

Alternate power adequate for the protection of the life and safety of patients and staff should be available in operative and recovery areas for surgical services.

8. Facilities and Environment (cont'd)

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
8. Existing facilities of accreditable organizations will, over a reasonable period of time, be brought into compliance with Section 13-6 "Existing Ambulatory Health Care Center," Chapter 27, and other sections as may be applicable, of the 1981 edition of the Life Safety Code® (NFPA 101®), published by the National Fire Protection Association, Inc., unless otherwise provided for by state law, local code, or appropriate jurisdiction having authority.	8.	x				

NOTE: Surveyors must complete the supplemental facility forms when surgery is performed in any of the organization's facilities. Also verify any reports that have been completed by acceptable state agencies regarding the codes, that have been submitted by the organization.

8. Facilities and Environment (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

9. Anesthesia and Surgical Services

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
ANESTHESIA SERVICES AND SURGICAL PROCEDURES IN AN ACCREDITABLE ORGANIZATION ARE PROVIDED AND PERFORMED IN A SAFE AND SANITARY ENVIRONMENT BY QUALIFIED HEALTH CARE PRACTITIONERS WHO HAVE BEEN GRANTED PRIVILEGES TO PERFORM THOSE PROCEDURES BY THE GOVERNING BODY. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS. General, regional, or supplemented local anesthesia is administered in the organization's facilities. Yes _X_ No ___ N/A ___ If yes, complete this entire chapter. If no, indicate what surgical procedures, if any, are done under local anesthesia only, and complete the relevant portions of this chapter. ______________________ ______________________ ______________________						
A. Anesthesia services provided in the facilities owned or operated by the organization are limited to those techniques that are approved by the governing body upon the recommendation of qualified medical personnel.	A.	X				
B. Adequate supervision of anesthesia services provided by the organization is the responsibility of one or more qualified physicians who are approved by the governing body upon the recommendation of qualified medical personnel.	B.	X				
C. Anesthesia is administered by anesthesiologists, other qualified physician or dentist anesthetists, qualified nurse anesthetists, or supervised trainees in an approved educational program.	C.	X				
D. A person qualified to provide anesthesia services is available as long as clinically indicated.	D.	X				
E. Policies and procedures are developed for anesthesia services which include, but are not limited to,	E.	X				
1. education, training, and supervision of personnel	1.	X				
2. responsibilities of non-physician anesthetists	2.	X				
3. responsibilities of supervising physicians	3.	X				
4. use and degree of supplemented local anesthesia	4.	X				

9. Anesthesia and Surgical Services

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

9. Anesthesia and Surgical Services (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
F. Anesthesia is not administered unless the operating surgeon or anesthesiologist has evaluated the patient immediately prior to surgery to assess the risk of the anesthesia relative to the surgical procedure to be performed.	F.	X				
G. Patients who have received anesthesia are evaluated by the operating surgeon or anesthesiologist after recovery from anesthesia, prior to discharge.	G.	X				
H. Patients who have received anesthesia, except unsupplemented local anesthesia, are discharged in the company of a responsible adult.	H.	X				
I. No patient shall receive general anesthesia unless one or more additional health care practitioners besides the one performing surgery are present or immediately available.	I.					X
J. All machines in use for general anesthesia shall have not less than one annual functional testing by technicians with appropriate training and a log of this testing will be maintained.	J.	X				
K. Surgical procedures performed in the facilities owned or operated by the organization are limited to those procedures that are approved by the governing body upon the recommendation of qualified medical personnel.	K.	X				
L. Adequate supervision of surgery conducted in the organization is a responsibility of the governing body, is recommended by an anesthesiologist or another physician, and is provided by appropriate personnel.	L.	X				
M. Surgical procedures are performed only by health care practitioners who	M.	X				
1. are licensed to perform such procedures within the state in which the organization is located	1.	X				
2. have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendation of qualified medical personnel and after medical review of the practitioner's documented education, training, experience, and current competence	2.	X				

9. Anesthesia and Surgical Services (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

9. Anesthesia and Surgical Services (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
N. Surgical procedures to be performed in an office surgical practice are reviewed periodically as part of the peer review portion of the organization's quality assurance program.	N.					X
O. An appropriate and current history, physical examination, and pertinent preoperative diagnostic studies are incorporated into the patient's medical record prior to surgery.	O.	X				
P. The necessity or appropriateness of the proposed surgery, as well as any available alternative treatment techniques, have been discussed with the patient prior to scheduling for surgery.	P.	X				
Q. Registered nurse(s) and other personnel assisting in the provision of surgical services are appropriately trained and supervised and are available in sufficient numbers for the surgical and emergency care provided.	Q.	X				
R. Each operating room is designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all persons in the area. At least one operating room is available for surgery.	R.	X				
1. Only nonflammable agents are present in an operating room, the room is constructed and equipped in compliance with standards established by the National Fire Protection Association (NFPA 56G, Standard for Inhalation Anesthetics in Ambulatory Care Facilities, 1980), and with applicable state and local fire codes.	1.	X				
S. An anesthesiologist or another physician qualified in resuscitative techniques is present or immediately available until all patients operated on that day have been discharged.	S.	X				
T. With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery are examined by a pathologist, whose signed report of the examination is made a part of the patient's medical report.	T.	X				

9. Anesthesia and Surgical Services (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

9. Anesthesia and Surgical Services (cont'd)

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
U. The findings and techniques of an operation are accurately and completely written or dictated immediately after the procedure by the health care practitioner who performed the operation. This description is immediately available for patient care and becomes a part of the patient's medical record.	U.	X				
V. A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, is assured through the provision of adequate space, equipment, and personnel.	V.	X				
1. Provisions have been made for the isolation or immediate transfer of patients with communicable disease.	1.	X				
2. All persons entering operating rooms are properly attired.	2.	X				
3. Acceptable aseptic techniques are used by all persons in the surgical area.	3.	X				
4. Only authorized persons are allowed in the surgical area.	4.	X				
5. Suitable equipment for rapid and routine sterilization is available to assure that operating room materials are sterile.	5.	X				
6. Sterilized materials are packaged and labeled in a consistent manner to maintain sterility and identify sterility dates.	6.	X				
7. Environmental controls are implemented to assure a safe and sanitary environment.	7.	X				
8. Suitable equipment is provided for the regular cleaning of all interior surfaces.	8.	X				
9. Operating rooms are appropriately cleaned before each operation.	9.	X				
W. When hospitalization is indicated or to evaluate, stabilize, and transfer when emergencies or unplanned outcomes occur, the organization either has a written transfer agreement for transferring patients to a nearby hospital when hospitalization is indicated or permits elective surgery only by practitioners who have admitting and similar surgical privileges at a nearby hospital.	W.	X				
X. Procedures have been developed for obtaining blood or blood products on a timely basis.	X.	X				
Y. Emergency power adequate for the type of surgery performed is available in operative and recovery areas.	Y.		X			

9. Anesthesia and Surgical Services (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

Y. An emergency power supply is present but was not operating at the time of the survey due to inadequate maintenance.

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

Emergency power adequate for the type of surgery performed should be available in the operative and recovery areas.

9. Anesthesia and Surgical Services (cont'd)

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
Z. Periodic calibration and/or preventive maintenance of equipment is provided.	Z.		X			
AA. The informed consent of the patient or, if applicable, of the patient's representative is obtained before an operation is performed.	AA.	X				
BB. A procedure has been established for the observation and care of the patient during the preoperative preparation and postoperative recovery period.	BB.	X				
CC. Protocols have been established for instructing patients in self-care after surgery, including written instructions to be given to patients who receive regional and general anesthesia.	CC.	X				

Is this organization (or a part thereof) licensed as an "ambulatory surgery center" by the state in which it is located? _X_ Yes ___ No ___ N/A

Is this organization currently certified as an "ambulatory surgery center" for participation in the Medicare program? _X_ Yes ___ No

If yes, please provide the Medicare provider number.__________

If yes, was the last Medicare Survey Report made available and reviewed on site? _X_ Yes ___ No

If yes, was the last report from the state or local agency responsible for code compliance made available and reviewed on-site? _X_ Yes ___ No

If no, does the organization plan to seek certification as a provider for Medicare? ___ Yes ___ No

9. Anesthesia and Surgical Services (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

2. Refer to comments on pages 45 and 55.

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

Refer to recommendations on pages 45 and 55.

10. Emergency Services

	COMPLIANCE
IF AN ACCREDITABLE ORGANIZATION IMPLIES BY ITS ACTIVITIES, ADVERTISING, OR PRACTICE THAT IT PROVIDES EMERGENCY SERVICES ON A REGULAR BASIS TO MEET LIFE, LIMB, OR FUNCTION-THREATENING CONDITIONS, SUCH SERVICES MEET THE NEEDS OF THE PATIENTS AND ARE PROVIDED IN ACCORDANCE WITH ETHICAL AND PROFESSIONAL PRACTICES AND LEGAL REQUIREMENTS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.	SC PC NC UNS N/A Is this standard applicable to this organization? Yes_____ No _X__ If yes, complete this chapter.
A. Emergency services are provided twenty-four hours per day every day of the year.	A. ___ ___ ___ ___ ___
B. Emergency services are performed only by health care practitioners who are licensed to perform such procedures within the state in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical personnel and after medical review of the practitioner's documented education, training, experience, and current competence.	B. ___ ___ ___ ___ ___
C. At least one qualified physician is present at all times.	C. ___ ___ ___ ___ ___
D. Personnel assisting in the provision of emergency services are appropriately qualified, trained, and supervised and are available in sufficient numbers for the emergency services provided.	D. ___ ___ ___ ___ ___
E. Unless otherwise provided for by the governing body, equipment, drugs, and other agents as recommended by the Emergency Care Guidelines of the American College of Emergency Physicians are available.	E. ___ ___ ___ ___ ___
F. Laboratory and diagnostic imaging services as described in chapters 13 and 14 of the Accreditation Handbook are immediately available.	F. ___ ___ ___ ___ ___
G. Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, and hospitals as needed to assure high-quality patient care.	G. ___ ___ ___ ___ ___
H. Adequate specialty consultation services are immediately available.	H. ___ ___ ___ ___ ___

10. **Emergency Services**

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

10. Emergency Services (cont'd)

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
I. Health care practitioners who maintain skills in advanced cardiac and trauma life support are present in the facility at all times.	I.	___	___	___	___	___
J. All emergency-services personnel maintain skills in basic cardiac life support.	J.	___	___	___	___	___

10. Emergency Services (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

11. Immediate/Urgent Care Services

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
IF AN ACCREDITABLE ORGANIZATION IMPLIES BY ITS ACTIVITIES, ADVERTISING, OR PRACTICE THAT IT PROVIDES MEDICAL CARE OF AN URGENT OR IMMEDIATE NATURE ON A ROUTINE OR REGULAR BASIS, SUCH CARE MEETS THE NEEDS OF THE PATIENTS AND IS PROVIDED IN ACCORDANCE WITH ETHICAL AND PROFESSIONAL PRACTICES AND LEGAL REQUIREMENTS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.	Is this standard applicable to this organization? Yes_____ No X If yes, complete this chapter.					
A. The range of services offered by the organization and its hours of operation are clearly defined and communicated to the public and relevant organizations.	A.					
B. Such organizations, unless they also provide emergency services, do not solicit patients with life-threatening conditions.	B.					
C. Patients seeking immediate/urgent care services are seen without prior appointments.	C.					
D. Immediate/urgent care services are performed only by health care practitioners who are licensed to perform such procedures within the state in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical personnel and after medical review of the practitioner's documented education, training, experience, and current competence.	D.					
E. During hours of operation, at least one qualified physician is present or immediately available.	E.					
F. The organization is prepared in terms of personnel, equipment, and procedures to evaluate, stabilize, and transfer medical emergencies that may present themselves or arise in conjunction with services provided by the organization.	F.					
G. Equipment, drugs, and other agents necessary to provide immediate/urgent care services are available.	G.					
H. Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, and hospitals as needed to assure high-quality patient care.	H.					

11. Immediate/Urgent Care Services

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

11. Immediate/Urgent Care Services (cont'd)

	COMPLIANCE					
		SC	PC	NC	UNS	N/A
I. Laboratory and diagnostic imaging services described in chapters 13 and 14 of the Accreditation Handbook are available to meet the needs of patients receiving immediate/urgent care.	I.					
J. Arrangements have been made to assure that adequate specialty consultation services are available.	J.					
K. Health care practitioners who maintain skills in cardiac and trauma life support are present in the facility at all times.	K.					

11. Immediate/Urgent Care Services (Cont'd)

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

12. Pharmaceutical Services

	COMPLIANCE					
PHARMACEUTICAL SERVICES PROVIDED OR MADE AVAILABLE BY AN ACCREDITABLE ORGANIZATION MEET THE NEEDS OF THE PATIENTS AND ARE PROVIDED IN ACCORDANCE WITH ETHICAL AND PROFESSIONAL PRACTICES AND LEGAL REQUIREMENTS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.		SC	PC	NC	UNS	N/A
A. Pharmaceutical services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	A.	X				
B. Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws.	B.	X				
1. Staff demonstrate knowledge of applicable state pharmaceutical laws.	1.	X				
2. Records and security are maintained to assure the control and safe dispensing of drugs in compliance with federal and state law.	2.	X				
C. Pharmaceutical services provided by the organization are supervised by a licensed pharmacist or, when appropriate, by a physician who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.	C.	X				
D. A pharmacy owned or operated by the organization is supervised by a licensed pharmacist.	D.					X
E. Pharmaceutical services made available by the organization through a contractual agreement are provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the organization.	E.					X
F. Patients are not required to use a pharmacy owned or operated by the organization.	F.					X

12. Pharmaceutical Services

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

13. Pathology and Medical Laboratory Services

PATHOLOGY AND MEDICAL LABORATORY SERVICES PROVIDED OR MADE AVAILABLE BY AN ACCREDITABLE ORGANIZATION MEET THE NEEDS OF THE PATIENTS AND ARE PROVIDED IN ACCORDANCE WITH ETHICAL AND PROFESSIONAL PRACTICES AND LEGAL REQUIREMENTS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.	COMPLIANCE					
		SC	PC	NC	UNS	N/A
A. Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	A.					X
B. Pathology and medical laboratory services include, but are not limited to,	B.					X
1. conducting laboratory procedures that are appropriate to the needs of the patients	1.					X
2. performing tests in a timely manner	2.					X
3. distributing test results within 24 hours after completion of a test and maintaining a copy of the results in the laboratory	3.					X
4. performing and documenting appropriate quality assurance procedures, including, but not limited to, calibrating equipment periodically, and validating test results through use of standardized control specimens or laboratories	4.					X
C. Dated reports of all examinations performed are made a part of the patient's medical record.	C.					X
D. Pathology and medical laboratory services provided by the organization are directed by a pathologist or another physician who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.	D.					X
E. Sufficient adequately trained and experienced personnel are available to supervise and conduct the work of the laboratory.	E.					X
F. Established procedures are followed in obtaining identifying, storing, and transporting specimens.	F.					X
G. Complete descriptions are available of each test procedure performed by the laboratory, including sources of reagents, standards, and calibration procedures, and information concerning the basis for the listed "normal" ranges is also available.	G.					X
H. Sufficient space, equipment, and supplies are provided to perform the volume of work with optimal accuracy, precision, efficiency, and safety.	H.					X

13. Pathology and Medical Laboratory Services

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

14. **Diagnostic and Therapeutic Imaging Services**

DIAGNOSTIC IMAGING SERVICES PROVIDED OR MADE AVAILABLE BY AN ACCREDITABLE ORGANIZATION MEET THE NEEDS OF THE PATIENTS AND ARE PROVIDED IN ACCORDANCE WITH ETHICAL AND PROFESSIONAL PRACTICES AND LEGAL REQUIREMENTS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.		COMPLIANCE				
		SC	PC	NC	UNS	N/A
A. Diagnostic and therapeutic imaging services provided or made available are appropriate to the patient and adequately support the organization's capabilities.	A.					X
B. Diagnostic imaging services include, but are not limited to,	B.					X
1. providing radiographic, fluoroscopic, or other diagnostic and therapeutic imaging services that are appropriate to the organization's function	1.					X
2. interpreting diagnostic images and other visual diagnostic documents, and supplying reports in a timely manner	2.					X
3. providing, in a timely manner, summaries of radiotherapy and other therapeutic procedures performed	3.					X
4. maintaining duplicate reports of services and retaining diagnostic images in the diagnostic imaging department for the time required by applicable laws and policies of the organization	4.					X
C. A radiologist authenticates all examination reports of specific procedures that may be authenticated by specialist physicians who have been granted privileges by the governing body or its designee to authenticate such reports.	C.					X
D. Authenticated, dated reports of all examinations performed are made a part of the patient's medical record.	D.					X
E. Diagnostic imaging services provided by the organization are directed by a physician who is qualified to assume professional, organizational, and administrative responsibility for the quality of the services rendered.	E.					X
F. Sufficient adequately trained and experienced personnel are available to supervise and conduct the work of the diagnostic imaging services.	F.					X

14. Diagnostic & Therapeutic Imaging Services

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

14. Diagnostic and Therapeutic Imaging Services (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
G. Policies address the quality aspects of the imaging services, including, but not limited to,	G.					X
1. performing imaging services only upon the order of a health care practitioner (such orders are accompanied by a concise statement of the reason for the examination)	1.					X
2. limiting the use of radioactive or other potentially harmful material to physicians who have been granted privileges for such use on the basis of their training, experience, and current competence	2.					X
H. Policies address the safety aspects of the imaging services, including, but not limited to,	H.					X
1. regulation of the use, removal, handling, and storage of potentially hazardous materials	1.					X
2. precautions against electrical, mechanical, magnetic, ultrasonic, radiation, and other potential hazards	2.					X
3. proper shielding where radiation, magnetic field, and other potentially hazardous energy sources are used	3.					X
4. acceptable monitoring devices for all personnel who might be exposed to radiation, magnetic fields, or otherwise harmful energy (suc monitoring devices are to be worn by personnel in any area with a potentially hazardous energy field)	4.					X
5. maintenance of invasive energy exposure records on personnel	5.					X
6. instructions to personnel in safety precautions and in dealing with emergency hazardous energy field exposure	6.					X
7. periodic evaluation by qualified personnel of energy sources and of all safety measures followed, including calibration of equipment, in compliance with federal, state, and local laws and regulations	7.					X
I. Adequate space, equipment, and supplies are provided to perform the volume of work with optimum accuracy, precision, efficiency, and safety.	I.					X
J. A policy addresses the retention of image records.	J.					X

14. **Diagnostic & Therapeutic Imaging Services (Cont'd).**

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

14. Diagnostic and Therapeutic Imaging Services (cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
K. Proper warning signs are in place, alerting the public and personnel to the presence of hazardous energy fields, emphasizing concern for particularly susceptible individuals, including	K.					X
1. pregnant females	1.					X
2. patients with pacemakers	2.					X
3. patients with metal implantations, including surgical clips for cerebral and abdominal aneurysm repair	3.					X
4. patients or personnel with magnetically inscribed credit cards	4.					X
5. patients or personnel wearing metallic objects capable of potentially dangerous motion	5.					X

14. Diagnostic & Therapeutic Imaging Services (Cont'd).

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

15. Occupational Health Services

	COMPLIANCE				
	SC	PC	NC	UNS	N/A
IF AN ACCREDITABLE ORGANIZATION PROVIDES OCCUPATIONAL HEALTH SERVICES, SUCH SERVICES ARE ORGANIZED TO ASSURE A SAFE AND HEALTHY WORKPLACE FOR EMPLOYEES, MEET THE NEEDS OF THE PATIENTS SERVED, AND ARE PROVIDED IN ACCORDANCE WITH ETHICAL AND PROFESSIONAL PRACTICES AND LEGAL REQUIREMENTS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.	Is this standard applicable to this organization? Yes ____ No __X__ If yes, complete this chapter.				
A. Occupational health services provided are in compliance with relevant standards promulgated by the Occupational Safety and Health Administration.					
B. Occupational health services are provided by personnel who have knowledge of the workplace hazards for each employee and the necessary and appropriate training and skills to carry out their assigned responsibilities.					
C. Pre-employment examinations are provided that consider the health of the individual and the requirements of the prospective workplace.					
1. Prospective job requirements are made known to the prospective employee and the examiner.					
2. Capabilities or limitations of the prospective employee are reviewed.					
3. Both the employer and the applicant are informed of the findings of the examination.					
D. Evaluations of employees absent from work are provided as needed to assure sufficient health to return to their particular workplace. Such evaluations include, but are not limited to,					
1. the extent and duration of potential hazards faced by the employee					
2. the extent and duration of the condition for the absence from work					
E. Health surveillance evaluations of employees are conducted at appropriate intervals to consider exposure to workplace hazards.					
1. Employees are advised of the results of such evaluations and any relationships to their health and employment.					
2. Employers are advised of the results of such evaluations and their impact upon the workplace.					
F. Employee education and training are provided on the adverse health effects of workplace hazards and methods by which such exposure might be reduced.					

15. Occupational Health Services

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

15. Occupational Health Services (Cont'd)

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
G. Employers are advised of any adverse health effects within an employee that might be attributed to the workplace. When adverse health effects are sufficient, removal of the employee from the hazard or attenuation of the hazard is advised so as to cause no further effects.	G.	___	___	___	___	___
H. An assessment of employees' lifestyle (diet, exercise, weight, and so forth) is provided, and specific practices are advised that might improve health.	H.	___	___	___	___	___
I. A system of records is maintained that meets the requirements of chapter six, Medical Records, of the Accreditation Handbook as well as the need for reporting of health surveillance data and other legal requirements.	I.	___	___	___	___	___
J. Where occupational health services are provided by a unit(s) within a larger organization, the sponsoring organization provides evidence of management understanding and commitment to the services provided.	J.	___	___	___	___	___

15. Occupational Health Services (Cont'd)

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

16. Other Professional and Technical Services

PROFESSIONAL AND TECHNICAL SERVICES PROVIDED OR MADE AVAILABLE BY AN ACCREDITABLE ORGANIZATION, EVEN THOUGH THEY ARE NOT SPECIFICALLY MENTIONED IN THE ACCREDITATION HANDBOOK, MEET THE NEEDS OF THE PATIENTS AND ARE PROVIDED IN ACCORDANCE WITH ETHICAL AND PROFESSIONAL PRACTICES AND LEGAL REQUIREMENTS. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.

COMPLIANCE

Is this standard applicable to this organization? Yes______ No__X__

If yes, complete this chapter.

	SC	PC	NC	UNS	N/A
A. Such services may include, but are not limited to, various medical specialties, audiology, dentistry, health education, nursing, nutrition, occupational therapy, optical services, physical therapy, psychology, social work, and speech therapy.	____	____	____	____	____
B. Such services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	____	____	____	____	____
C. Such services are provided in accordance with ethical and professional practice and applicable federal and state laws and regulations.	____	____	____	____	____
D. Such services are evaluated by using applicable standards from other chapters of the Accreditation Handbook.	____	____	____	____	____

List which other professional and technical services were reviewed:

List any professional or technical services offered by the organization that were not reviewed, and explain why.

16. Other Professional and Technical Services

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

17. Teaching and Publication Activities

		COMPLIANCE				
		SC	PC	NC	UNS	N/A
IF STAFF ARE INVOLVED IN TEACHING OR PUBLISHING, AN ACCREDITABLE ORGANIZATION HAS POLICIES GOVERNING THOSE ACTIVITIES THAT ARE CONSISTENT WITH ITS MISSION, GOALS, AND OBJECTIVES. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.	Is this standard applicable to this organization? Yes______ No__X__ If yes, complete this chapter.					
A. Policies concerning teaching activities address	A.					
1. the terms and conditions of reimbursement or other compensation	1.					
2. the reasonableness of the time spent away from direct patient care and administrative activities	2.					
3. the training of all students and postgraduate trainees, including the extent of their involvement in patient care activities	3.					
B. The policy concerning the provision of health care by personnel in any student or postgraduate trainee status provides for close and adequate supervision and for informing the patient of the status of the provider.	B.					
C. Policies concerning publishing activities address	C.					
1. the need for governing body approval when the views, policies, and procedures expressed in the publication are attributed to the organization	1.					
2. the terms and conditions of compensation from publication, and the cost of publication	2.					

17. **Teaching and Publication Activities**

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

18. Research Activities

Standard	COMPLIANCE				
	SC	PC	NC	UNS	N/A
IF RESEARCH IS CONDUCTED, AN ACCREDITABLE ORGANIZATION ESTABLISHES AND IMPLEMENTS POLICIES GOVERNING RESEARCH THAT ARE CONSISTENT WITH ITS MISSION, GOALS, OBJECTIVES, AND WITH ITS CLINICAL CAPABILITIES. SUCH AN ORGANIZATION HAS THE FOLLOWING CHARACTERISTICS.	Is this standard applicable to this organization? Yes______ No__x__ If yes, complete this chapter.				
A. Research activities are performed in accordance with ethical and professional practices and legal requirements, and these activities are periodically monitored. Such activities include, but are not limited to, clinical trials of drugs and other biologicals, devices, implants, or instuments that are classified as investigational or experimental, and techniques that are new, experimental, innovative, or otherwise not yet accepted as standard medical practice.	A. ____	____	____	____	____
B. The protocols for conducting research are approved by the governing body or its designee after medical and legal review.	B. ____	____	____	____	____
C. Any research activities carried out within the organization are appropriate to the expertise of staff and the resources in the organization.	C. ____	____	____	____	____
D. Individuals engaged in research are provided with adequate facilities.	D. ____	____	____	____	____
E. Provision is made to assure that the rights and welfare of all research subjects are adequately protected and that the informed consent of the subject, in the language spoken by him or her, is obtained by adequate and appropriate methods.	E. ____	____	____	____	____
F. All professional staff are informed of the organization's research policies.	F. ____	____	____	____	____

Surveyors should ascertain whether or not staff are familiar with federal regulations governing human subjects research.

18. Research Activities

SUPPORTING AND SUMMARY COMMENTS:

CONSULTATIVE COMMENTS MADE TO THE ORGANIZATION NOT RELATED TO THE STANDARDS:

RECOMMENDATIONS MADE TO THE ORGANIZATION REGARDING THE STANDARDS:

SUMMARY TABLE

There is substantial compliance with the characteristics listed in the AAAHC Handbook addressing:	SC	PC	NC	UNS	N/A
1. Rights of Patients	X				
2. Governance	X				
3. Administration	X				
4. Quality of Care Provided		X			
5. Quality Assurance Program		X			
6. Medical Records	X				
7. Professional Improvement	X				
8. Facilities and Environment		X			
9. Anesthesia and Surgical Services	X				
10. Emergency Services					X
11. Immediate/Urgent Care Services					X
12. Pharmaceutical Services	X				
13. Pathology and Medical Laboratory Services					X
14. Diagnostic & Therapeutic Imaging Services					X
15. Occupational Health Services					X
16. Other Professional and Technical Services					X
17. Teaching and Publication Activities					X
18. Research Activities					X

There is substantial compliance with the characteristics listed in the AAAHC Handbook describing an accreditable organization.	YES	NO
	X	

Accreditation Association for Ambulatory Health Care, Inc.

9933 LAWLER AVENUE • SKOKIE, ILLINOIS 60077-3702 • (312) 676-9610

Ronald S. Moen
Executive Director

Dear Dr.

It is our pleasure to inform you that the has been accredited for a term of one year by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). The accreditation term is effective as of The dedication and effort necessary for an organization to be accredited is substantial. Your organization is to be commended for this accomplishment.

The granting of this accreditation reflects our confidence, based on evidence from your recent survey, that you meet, and will continue to exhibit throughout the accreditation term, the attributes of an accreditable organization as outlined by the standards in the Accreditation Handbook for Ambulatory Health Care. The spirit of those standards implies a commitment to continual self-evaluation and improvement.

We encourage your organization to review carefully the survey report as a guide to the ongoing process of self-evaluation. "Recommendations made to the organization regarding standards" are directly related to the standards and require corrective action. Consequently, any subsequent surveys by the AAAHC will seek evidence that recommendations from this survey have been addressed without serious delay and that the attributes of an accreditable organization as expressed in the standards have been continuously evident during the term of accreditation. Statements in the "consultative comments" section of the report are part of the "consultative" portion of the survey. They do not affect the accreditation decision, and therefore are not considered to be deficiencies.

The decision to grant a one year term of accreditation is based on the areas of Quality of Care Provided and Quality Assurance, which are in partial compliance with the standards. Therefore, the following recommendations should be addressed without delay:

Quality of Care Provided - The provision of high-quality health care services should be demonstrated by the absence of clinically unnecessary diagnostic or therapeutic procedures; and appropriate, accurate, and complete medical record entries. Concern for the costs of care should include the relevance of health care services to the needs of the patients; and the use of the least expensive alternate resources when suitable (refer to Standard 4 and pages 20-23 in the survey report); and

Quality Assurance - Efforts should be continued to ensure that the professional staff understands the quality assurance program which should address clinical, administrative, and cost-of-care issues, as well as actual or potential problems affecting patient outcomes. Health care practitioners should participate in the development and application of the criteria used to evaluate the care they provide. Collected data should be periodically evaluated to identify unacceptable or unexpected trends or occurrences that influence patient outcomes. Important problems or concerns in the care of patients should be identified and reevaluated to determine objectively whether the corrective measures have achieved and sustained the desired result (refer to Standard 5 and pages 24-29 in the survey report).

The following recommendations, which did not affect the one year term, should also be addressed:

Facilities and Environment - Equipment should be properly maintained and periodically tested. Alternate power adequate for the protection of the life and safety of patients and staff should be available in operative and recovery areas for surgical services (refer to Standard 8 and pages 40-47 in the survey report); and

Anesthesia and Surgical Services - Emergency power adequate for the type of surgery performed should be available in the operative and recovery areas (refer to Standard 9 and pages 48-57 in the survey report).

Enclosed is a survey evaluation form, an accompanying explanation, and a self-addressed envelope. Please assist the AAAHC as it continues its efforts to improve the accreditation survey process by returning the completed form to the AAAHC office.

If you have any questions or comments about any portion of the accreditation process, please do not hesitate to contact Gayle Elliott at the AAAHC offices.

In order to maintain your accredited status, please be certain to contact the AAAHC six months prior to the expiration date of your term to schedule your next accreditation survey.

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It is our sincere hope that you will continue to find your accreditation experience worthwhile, not only from the recognition that your participation in this survey process brings, but also from the benefit of having carefully reviewed your own operation.

Sincerely,

Nicholas D. Wing, MD
President
Accreditation Association for
Ambulatory Health Care, Inc.

cc: